



LUND UNIVERSITY
Faculty of Social Sciences

A Need for Supportive Structures for Next-of-kin caregivers in Botswana

Author: Leah Dahlgren

SIMV07, Master's Thesis (Two Years) in Social

Studies of Gender

SPRING Term 2012

Supervisor: Bodil Rasmunsson

Acknowledgments

My deepest appreciation to my supervisor Bodil Rasmunsson for her consistent devotion in the supervision of my work. You believed in me right from the beginning and continued to give me the confidence to finish this valuable research.

My sincere gratitude to the Gender Studies department at Lund University for paving the path to the production of this final research, thank you.

Most of all, my utmost appreciation to Irene Mokgwathi and the women in Moshaweng that participated in this study and for trusting in me, sharing your stories that provided valuable information for my research.

To my family both here in Sweden and in Botswana, thank you for your consistent support. You never stopped believing in me.

Abstract

Author: Leah Dahlgren

Title: **A Need for Supportive Structures for Next-of-kin Caregivers**

SIMV07, Master's Thesis (Two Years) in Social Studies of Gender

Supervisor: Bodil Rasmunsson

Lund University

Department of Social Work

Spring Term 2012

Botswana is one of the countries struggling with the control of HIV/AIDS pandemic. Due to the increase in numbers of sick people weighing financially on the health system, the government has introduced home-based care policy. The policy is characterized by the reliance on family members for the care of people with AIDS-related sicknesses and this care is mostly given by women, adding to an increase in their existing unpaid care work. This thesis explores the experiences of the next-of-kin women giving care to people with AIDS-related sicknesses in Botswana under the home-based care policy. The theories applied in the thesis include social role theory to understand the reasons why more women than men are caregivers; the concept of the situated knowledge in feminist standpoints to understand the how the women see their roles as caregivers; and gender perspective connected to poverty and care giving as more women are forced to continue to spend time in unpaid employment. Through the analysis of the interviews, the conclusion is that while the next-of-kin caregivers have to take on the increased burden of giving care for their sick relatives there is lack of supportive structures for both the sick persons and their caregivers to turn to for help. The author shows that the next-of-kin caregivers are unable of taking any kind of employment and therefore continue to live in poverty. The conclusion is even that there is a need for financial support, active support from the health care department and constructive support from the social services aimed at the next-of-kin caregivers in their daily work.

Keywords: Supportive structures, caregivers, home-based care, social roles, poverty, Botswana and feminist standpoints.

List of Acronyms

AIDS.....Acquired Immune Deficiency Syndrome

CD4.....Cells with molecules that help initiate the body's response to invading viruses

CHBC.....Community Home-Based Care

GNP.....Gross National Product

HBC.....Home-Based Care Policy

HIV.....Human Immune Virus

MDG.....Millennium Development Goal

MTP.....Medium Term Plan

NACA.....National AIDS Coordinating Agency

PHC.....Primary health care

PLWHA.....People Living with HIV/AIDS

TB.....Tuberculosis

UN.....United Nations

UNAIDS.....United Nations Programme on HIV/AIDS

UNDP.....United Nations Development Programme

UNIFEM.....United Nations Development Fund for Women

WHO.....World Health Organization

Table of contents

1 INTRODUCTION	1
1.1 RATIONALE OF THE STUDY	1
1.1.1 HOME-BASED CARE POLICY (HBC)	2
1.1.2 STATEMENT OF THE PROBLEM	3
1.2 AIM OF THE STUDY	4
1.3 RESEARCH QUESTIONS	4
1.4 LIMITATIONS OF SCOPE	4
2 BACKGROUND	5
2.1 THE COUNTRY OF BOTSWANA.....	5
2.2 TRADITIONAL FAMILY SETTINGS.....	6
3 LITERATURE REVIEW & FRAMEWORK.....	8
3.1 RELEVANT LITERATURE REVIEW	8
4 THEORETICAL FRAMEWORK	13
4.1 THE SOCIAL ROLE THEORY	13
3.2.2 FEMINIST STANDPOINTS.....	15
3.2.3 GENDERED POVERTY	18
4 RESEARCH METHODOLOGY	20
4.1 RESEARCH STRATEGY	21
4.1.1 PRE-CONCEPTIONS	21
4.1.2 QUALITATIVE METHODS	22
4.1.3 TARGET SAMPLES	23
4.1.3.1 SELECTION OF INFORMANTS	23
4.1.3.2 BAKGALAGADI IN MOSHAWENG	26
4.1.3.3 KEY-INFORMANTS	27
4.1.3.4 CAREGIVERS	27

4.2 DATA COLLECTION	29
4.2.1 PREPARATORY WORK	29
4.2.2 INTERVIEW SITUATION	29
4.3 LIMITATIONS AND TECHNICALITIES	30
4.4 ETHICAL CONSIDERATIONS	30
4.5 RELIABILITY OF THE STUDY	31
5 RESEARCH FINDINGS & ANALYSIS	32
5.1 THE ROLE OF THE STATE IN SUPPORT FOR CAREGIVERS OF PEOPLE LIVING WITH HIV/AIDS	33
5.1.1 SOCIAL POLICIES, HEALTH CARE POLICIES AND THE HOME-BASED CARE POLICY	33
5.2 THE CAREGIVERS' EXPERIENCES OF THE SOCIAL SERVICES' INTERVENTIONS	35
5.1.2 KNOWLEDGE OF THE HOME-BASED CARE POLICY BY THE CAREGIVERS	39
5.3 THE CAREGIVERS' EXPERIENCE OF THE HEALTH SERVICES INTERVENTIONS	41
5.4 THE ROLE OF THE EXTENDED FAMILY IN THE SUPPORT SYSTEM FOR THE CAREGIVER IN THEIR IMMEDIATE FAMILY	44
5.5 PERSONAL EXPERIENCES OF THE CAREGIVERS IN THEIR CARE WORK	46
5.6 THE FAMILY'S ECONOMY	49
6 DISCUSSION	52
7 CONCLUDING REMARKS	56
REFERENCES	57
BOOKS AND ARTICLES	57

1 Introduction

1.1 Rationale of the Study

As the rate of poverty in the world continues to spread, some parts of the world are more affected than others. The developing countries are experiencing deterioration in living standards especially for the unemployed, the poor and the malnourished (Antonopoulos & Hirway, 2009). Women in particular are affected by the burden of poverty which is partly contributed by gender-based unpaid work. Women are still viewed as responsible for carrying out unpaid work such as; maintaining the household and sanitation, food processing and meal preparation, collecting of firewood, water and other free goods and volunteer and care for the children, the elderly and the sick (ibid).

The amount of poverty for women in developing countries has become a heavier burden as the amount of unpaid work has increased due to the increased rate of HIV/AIDS (Akintola, cited in Antonopoulos & Hirway, 2009) The persistent crises of HIV/AIDS, poverty and patterns of inequalities between the nations, social classes and households shape and are shaped by the gender divisions of labour and household in the developing countries struggling with the HIV/AIDS pandemic (ibid). The spread of HIV/AIDS has affected the whole world and continues to be the major threat to global health and economic growth as the welfare of the households, communities and societies is affected (UNAIDS 2009). UNAIDS reports that the year 2008 there were 32.9 million people infected by HIV/AIDS in the world and 22,4 million of the infected people live in Sub-Saharan Africa (UNAIDS, 2009). Already before the HIV/AIDS pandemic, countries in Africa South of the Sahara had been struggling with developmental issues and with the spreading of the disease mostly affecting the fertile adults in their prime ages between 15 - 49 years, there has been a devastating contribution for the households and societies both socially and economically (ibid). While taking care of the terminally sick, the women are unable to take up any kind of work that can generate income, as they have to both take care of the children and take care of the sick next-of-kin (Akintola, 2009).

Due to the impact by HIV/AIDS in the region that has also resulted on a heavier load on the health care services both financially and physically, a Home-Based Care policy (HBC) was introduced in 1990 (National AIDS Coordinating Agency of Botswana, 2008).

1.1.1 Home-Based Care Policy (HBC)

With the HIV/AIDS epidemic, unpaid care, gender and poverty have yet to receive adequate attention. Home-based-care has emerged as a key response to the epidemic in Botswana and other countries in Africa South of Sahara. The underlying characteristic of this policy is the reliance on family members without any compensation and with little training and support (Antonopoulos & Toay, 2009). This response is partly due to the pressures put on the existing health care system and fiscal budgets. It is estimated that approximately 70 – 90 percent of people with AIDS are being cared for by their next-of-kin (Akintola, 2008). With the heavy load on the health system by the HIV/AIDS, HBC policies were introduced in many countries in the sub-Saharan Africa. In Botswana the HBC policy has existed since 1990 (Lindsey et al. 2003). The rationale for the implementation of HBC is that it is seen as the best method to care for the many terminally sick people. However the care of the sick did not start with the introduction of HBC policies, families were already providing care for their relatives in their homes but this care was less demanding for caregivers as it only meant providing supportive care (Akintola, 2009).

Before the HBC policy the terminally bedridden people were hospitalized for longer periods of time and with the number of HIV/AIDS patients' dramatic increase, the health care system was experiencing enormous strain, leading to the government's introduction of structural adjustment policies such as the HBC (Akintola, 2006). The health care reforms required massive cut backs in spending on public health care and development programs. At the same time as the medical care for people living with HIV/AIDS (PLWHA) was devastating for the economy of the government on hospitals, the bad working conditions also led to a brain drain, reducing the human capacity of qualified medical staff from Botswana and other countries in sub-Saharan Africa (Campbell et al. 2004). The requirement with HBC policy is that the home is the primary place of care for the PLWHA's in the care of family members provided with little support such as gloves and soap from the formal health facilities (Lindsey et al, 2003). While HBC is beneficial for cost reduction in the formal health care services, it is also crucial to put light on the interconnection of women's unpaid care work the social roles the gender perspective and poverty.

1.1.2 Statement of the Problem

Many feminist scholars have written about the gendered dimension of unpaid care and unpaid AIDS care is a new addition to the list of unpaid work carried out by women. This study has a focus on caregivers who carry out AIDS care without payment. This unpaid AIDS care work is gendered in consistence with women's traditional roles of caregiving. Studies show that caregivers consist of mainly mothers, grandmothers, sisters, wives, girlfriends and female friends (Lindsey, et al, 2003). Children, especially girls are also forced to take upon the roles of care work where there are no adults and sometimes perform supportive roles in care work (ibid).

Recent years have acknowledged the exclusion of women from fundamental rights in the social, economic and political arena and have gained ground in the debate on development work. According to the United Nations Development Programme's Millennium Development Goals (MDG:s), work is put towards eradicating poverty and deal with gender inequality in societies, putting women into focus in the economic and social development work, but men seem to be the main gainers of the progress made, and patriarchal structures remain unchallenged (Kabeer, 2004). However, a firm belief in gender mainstreaming has now deeply penetrated the development discourse and strategies of strengthening poor communities through women are considered most effective ways of addressing poverty (ibid). The MDG outlines strategies with a particular focus on women empowerment. Poverty has the face of a woman, thus the attempt to reduce poverty should start with women, whereby resource allocations with women in the center is a lucrative investment (Eswaran & Asholc, 1994). Women are considered the way out of poverty, not only because they constitute the majority of the poor, but also because women tend to use their earnings for the benefit of family at large to a greater extent than men do (Agarwal, 1994). Thus the aim of gender sensitive development strategies should be twofold; on one hand they should aim to strengthen women because they constitute the majority of the poor and on the other hand to reach out to the poor families through women. Women should therefore be the target group in the development work for eradication of poverty. Unfortunately some policies, such as the Home-Based Care only worsen the women's situation. The introduction of the HBC policies in Botswana meant that poor people and especially the women had to take on more responsibility in the care of AIDS patients than they had before (Akintola, cited in Antonopoulos & Hirway, 2010).

1.2 Aim of the Study

In light of the HBC policy and the care work, the purpose of this study is to explore the experiences of next-of-kin caregiving women burdened by poverty, unpaid care work for AIDS patients and the traditional unpaid family care work without any governmental support. It is based on individual interviews, putting a major focus on the experiences of the next-of-kin caregivers, in their daily work in terms of gender and supportive structures. Locating this process in the discourse of poverty dominated by cultural male stereotyped practices, I seek to illuminate symbolic as well as material dimensions of poverty (Lister, 2004). Emphasising on a gender sensitive development perspective I focus on the lived experiences of next-of-kin caregivers and the contribution of cultural practices in women's unpaid AIDS care work. The retrogressive cultural practices and traditions have perpetuated the negative attitudes and the subordination of women in Botswana that partly have its roots in societal beliefs and expectations (Richardson, 2004). Women have a lower position in the society and this is reinforced by the socialization of both women and men. This study has its focus on the widespread poverty faced by women as caregivers of people living with HIV/AIDS in Botswana, one of the countries struggling with the control of the epidemic. I strive to analyze the lived experiences of the caregivers in the context of gendered practices that are the results of governmental policies in the work against AIDS.

1.3 Research Questions

- Is there any governmental assistance offered to caregivers and their families?
- What is the experience of women in their roles as caregivers?
- What are the standpoints taken by the women in regard to care giving and poverty?

1.4 Limitations of Scope

This study is conducted in a rural village, Moshaweng in Botswana. The study explores and describes poverty amongst next-of-kin caregivers of people living with HIV/AIDS (PLWHA) with focus on gender. The purpose of the study is to explore the lives of women burdened by poverty, unpaid AIDS care work and the traditional unpaid family care work. The study also describes the fading traditional kinship relations where elderly women who used to be taken care of by their children and their grandchildren have now changed as an effect of the HIV/AIDS epidemic. The elderly have now taken over the role of care work. The participants of the study

includes three key-informants from governmental institutions; one deputy chief of Social Work Department in Kweneng district, the HIV/AIDS programme coordinator in Kweneng district and the public relations officer of the National AIDS Coordinating Agency of Botswana (NACA); followed by 8 individual interviews with next-of-kin caregivers in Moshawaweng. The study further briefly touches on the cultural aspect of gender in traditional Botswana. This study does not include the policy making in Botswana and therefore does not suggest any methods on policy making in Botswana.

2 Background

2.1 The Country of Botswana

Botswana lies in Africa South of the Sahara in the Kalahari Desert totally landlocked by Zambia, Zimbabwe, Namibia and South Africa. The country is sparsely populated with a population of just over 1.949,780 million people year 2009 (The World Bank, 2011) on a 582,000 square kilometers and has been described as one of the fastest growing economies in Africa since the country's independence from British colonialism in 1966. The country has made big progress towards development in many ways. The national language in Botswana is Setswana and English is the official language (Ibid).

Botswana has had a stable social structure and benefitted from a wealth of natural resources such as diamonds and coal, the rich unique wild life that has many tourists visiting the nature parks and the Okavango Delta. The country also has an unbroken record of parliamentary democracy and one of Africa's highest sustained records of gross national product (GNP) growth since independence. Botswana has come to be recognized as one of the few African countries classified as "upper middle class" (Medium Term Plan [MTP], 1997 – 2002:5). The education and health care system are public funded in Botswana, which means that both primary and secondary schools are free with adult literacy at 70%. The Primary health care (PHC) is predominantly free and universally free for children, pregnant women, TB patients and HIV/AIDS patients (www.moh.gov.bw).

Despite the relative success of the country, 47 percent of the population in Botswana is living in poverty, mostly in the rural areas. There is also a high rate of female-headed households and the majority of these live in poverty (<http://www.unbotswana.org/bw/undp/poverty.html>). Botswana is also one of the countries highly affected by the HIV/AIDS pandemic with statics reaching as

high as 25, 9 percent of HIV/AIDS prevalence in Botswana by the year 2008 among adults aged 15 – 49 (UNAIDS, 2009). With the health services struggling to keep up with the load of caring for people with AIDS, the terminally sick are left for the next-of-kin to care for. In Botswana, like in most countries, care work has culturally been allocated to women. In accordance with the Millennium Development Goals (MDGs) the government of Botswana has set up programmes under the Vision 2016, in order to fight the war of HIV/AIDS and the persistent poverty. Despite these many programmes, there is still widespread poverty amongst the societies and mostly for the poor affected families and the allocated resources are not reaching the poor (Ministry of labour and Home Affairs, November, 2000).

2.2 Traditional Family Settings

The African continent, especially the Sub-Saharan Africa has deep-rooted kinship systems as well as the extended family networks, and these have been part of Botswana, acting as a social security for the children, the elderly and the sick people whereby relatives and family members can always rely on support for care. Women have mainly been the bearers of this support system and have had to pay the price of caring within a gendered division of labour (Lister, 2004). Under the pressure of AIDS, the support systems are on the verge of breaking with women stuck in the caring work and in their poverty. These are the same women who have always been able to provide for their families despite being trapped in poverty for decades, but the uniqueness of caring for people with AIDS has led to difficulties in earning enough money to support themselves and their families. Elderly women have also been forced to take on the tremendous burden of caring for their sick children, causing a collapse in the family network and social support system whereby the elderly used to be cared for and economically provided for by their children. The changing in the support system is mostly visible in the rural areas where most of the people have already been living in poverty and the government programmes are not reaching them (NACA, Botswana, 2008).

Despite the efforts to accede to international, regional and local policies and laws of protecting women, Botswana is still lacking in the arena of the rights of the women. Women are still subordinate to men at various levels and there are many loop holes in laws and policies affecting women and children (Physicians for human rights, 2007). This can be identified by the various limitations on women's rights to employment, leading to the widespread poverty amongst women

and the community at large. The greatest obstacle is the unquestionable discrimination experienced by women at the different levels. Cultural attitudes also limit women's effective participation in economic activities, as men are culturally accepted as the main breadwinners and the sole decision makers (National Gender Framework, 2004). Thus the poor economic potential of women and the disadvantages they experience through their limited access to stable income generating activities lead to poverty (Ibid). Next-of-kin caregiving of people with AIDS-related sickness have come to play a big part in the widespread poverty among women in rural Botswana (National Gender Framework, 2004).

Even though poverty among women is not a new phenomenon, it has now escalated due to the epidemic and the traditional settings of family systems as a whole are threatened to diminish under the pressure of AIDS in the society as even the elderly women are forced to take care of their adult children. Additionally, women in Botswana have been led to believe that problems in the home should be kept private, taught not to 'wash their dirty linen in public', as this tarnishes the family name (Women's Affairs Department, 2003). Tradition has always placed the woman in subservient roles, considering her to be a perpetual minor whose guardianship is passed on from the father to the husband upon marriage (ibid). In an addition to being considered unable to think for herself, the woman is burdened with the most labour intensive and least rewarding occupations in the society. Women have always been a big part of the subsistence farming that contributes to the economy of the family which in turn is controlled by the men. Both the individual and society at large are being affected by the widespread HIV/AIDS and there is a need to draw focus to both these areas and supporting solutions to be made to sustain the value of the women and family life even in rural Botswana (ibid). The picture of women in the big towns and those in the rural areas has changed dramatically as more women get education that lead to employment and autonomy. The women in the rural areas are less educated and still continue in the traditional ways of living in Botswana despite the wealth of information available for attitudinal change. However, the manner in which the information is packaged is not user friendly and is not presented in a manner that targets the illiterate and the follow up and evaluations of implementations and imposed policies are not of best quality (Women's Affairs Department, 2003).

3 Literature Review & Framework

3.1 Relevant Literature Review

In this part of the study I present a brief overview of the existing literature looking firstly at the international research about next-of-kin caregivers concentrating mostly on research done in Scandinavia and then going on to present research done in Africa, with focus on Southern Africa. As already mentioned, caregiving as a phenomenon has been researched by many and for the purpose of this study; I shall mainly limit myself to relevant research for my study. There is an abundance of scientific literature on caregiving by next-of-kin. To name but just a few, these include (Sandberg, et. al, 2009; Amberg, 1999; Tarroberelli, 1993; Nolan et. al, 1996, Orner, 2006; Russel & Schneider, 2000; Dullarbh, 2002; Akintola, 2006, 2010 and Lindsey et. al, 2003)

Most of the literature on family caregiving for PLWHA worldwide shows the negative implications of caring for the caregiver, usually. For instance, family caregiving has been shown to result in poor health and socio-economic outcomes for caregivers. Family caregivers of people living with HIV/AIDS experience stigma and discrimination and are isolated from sources of support. Some studies reveal that caregivers, predominantly women, experience severe economic burdens from caring. Caring is reported to undermine the ability of women to work on the farm, thereby creating food insecurity.

3.1.1. International research on caregiving

Caregiving is a well-recognized phenomenon in Sweden and the rest of the Scandinavian countries. The recent years have experienced a lot of research showing that even though Sweden has a well-established social security where special care is provided for the elderly, the sick and the disabled, a great majority of the care is done by the next-of-kin. Most of the research done in the western countries about care work also incorporates the welfare system (Sandberg et al., 2009). This is because of the well-structured support system in the European countries that is non-existent in the developing countries.

In Sweden despite the structure of the social security network whereby the government has set up care for the terminally sick people and the old, many of these are still cared for by their next-of-kin (Sandberg, et al, 2009). In 1997 the Swedish government decided to invest 100 Million Kronars each year between 1999 and 2001 towards the care and support of the next-of-kin

caregivers in municipal work in a project called "Anhörig 300" (Socialstyrelsen.se). This was a way to start recognizing the amount of work put on by the next-of-kin in caring for the elderly, the terminally sick and disabled relatives. The law was also adjusted to add that *"the social welfare board should give support and relief for those caring for chronically ill, elderly or disabled relatives"* (lag 1997:313) (the author's translation). This was a way for the Swedish government to recognize their responsibility towards the support for the next-of-kin caregivers. During the following years after this change of law much work has been put towards a working support system for the caregivers (Anhörig 300: Slut rapport, 2002).

The end report for the project concludes that the money was used for employing people for overseeing the project in each municipality, a care support in the sick people's home, educating the next-of-kin caregivers, study circles, educating the staff in the special care homes about matters relating to next-of-kin caregivers, gathering information, healthcare research, creating meeting places for the caregivers and other resources such as relaxation spas for the caregivers (Anhörig 300: Slut rapport, 2002). The conclusion is that there were new forms of support systems for the next-of-kin caregivers and the support that existed before the project had improved tremendously (ibid).

The important issue in this report is that it gives light to the fact that it is important to understand the caregivers' situation to be able to support them based on their situation (Amberg, 1999). My conclusion on the report is that in Sweden and many Scandinavian countries, the government has realised the importance of supporting the next-of-kin caregivers despite the existing welfare system hence the supportive structures.

On the other hand, in a recent article by Sandberg and colleagues, *"Keeping the family balance - adult daughters' experiences of roles and strategies when supporting caring fathers"* (2009), Sandberg criticises the little attention given to gender equality in old age and the normative constructions of gender intersect in the lives of next-of-kin caregivers. In the study the authors use "gender equality", "normativity", "traditional roles" and "strategies in supporting" as a framework for their analysis. The main conclusion drawn from the research is that daughterhood connected to family caring could be understood as a social responsibility whereby the daughters are expected and expect themselves to be the sole supporter of their caring fathers (Sandberg et al, 2009). Furthermore, these daughters carry an expectation and play a leading part in family

care that in turn raises feelings of role captivity in their own lives whereby the next-of-kin take on the role of caregiving without fully realising the meaning of it (Tarroberelli, 1993 and Nolan et al, 1996 cited in Sandberg et al. 2009). The authors further argue that women's position as informal caregivers is often assumed and taken for granted in social policy and indeed by the women themselves. Their argument is that the intersecting structure impacting on the daughter's situations are largely invisible and might be made visible through a gender lens and where the argument is that the dominant gender-based expectation remains important in that daughters more frequently adopt a caregiver role (Sandberg, et al., 2009). The study by Sandberg et al, (2009) is somewhat in conjunction with my study except there is no mention of the poverty experienced by the caregivers.

3.1.2. Local research on caregiving: Sub-Saharan Africa

In this section, previous research based on home based care for people living with HIV/AIDS in Sub-Saharan Africa is introduced. The presented research deals with the care of people living with HIV/AIDS by next-of-kin in Africa South of Sahara. While some researchers have proclaimed home-based care as advantageous for the sick people, other scholars have found out that the HBC policies has contributed to hidden cost impacts for the involved families, deteriorated health and contributing to the existing gender inequalities in the society and care work, especially in the developing countries.

Most of the research on next-of-kin caregiving for people living with HIV/AIDS is based in Africa, mostly in the Sub-Sahara Africa. This research also concentrates on the implications of caregiving on the caregivers' both psychologically and physically, but even on the socio-economic implications on caregivers. In the studied research, the common denominator is that most of the caregivers are women, suffering under the burden of unpaid care work and as a result of poverty. Many of the studies have failed to address deeply what I see as one of the main important factors as to why only women are taking part in the caregiving of people living with HIV/AIDS, thus the culturally prescribed gender roles that have continued to oppress the African women.

South Africa is one of the leading countries in research on caregiving for HIV/AIDS. I found research by Phylis Orner (2006), Akintola (2004), Russel & Schneider (2000), Dullarbh and

Elizabeth Lindsey et al (2003) consistent with my study. A study conducted in a semi-rural area in South Africa done by Akintola (2006) called "*Gendered home-based care in South Africa: trouble for the troubled*" concludes that the home-based care policies undermine women's health and wellbeing. In the study the author uses "gender inequalities", "poverty" and "mental health" as a framework in analysing. Alogoke Akintola is one of the most well-known names in the HIV/AIDS care research. In this study, research was conducted in a semi-rural area in South Africa amongst 41 caregivers of people living with HIV/AIDS, 39 women and 2 males. The writer argues that "*home-based care undermines women's health and wellbeing; creating an inordinate burden on women and thereby exacerbating existing gender inequities*" (Akintola, 2006). Akintola recommends that, gender perspectives be incorporated in the planning and implementations of home-based care policies, that homes should be assessed as *capable and willing* to care for the patient before they are discharged from hospitals. The recommendation is also to introduce training of primary caregivers by the government as well as the importance of universal precautions to reduce infections. The writer further calls for the need to relieve caregivers in their work, the need to provide quality mental care monitoring of caregivers, and lastly a call for further research to investigate the willingness of families to care for people living with HIV/AIDS which may lead to better understanding of the socio-cultural factors that make women provide care, therefore even better understanding of the negative implications of the family by home-based care (Akintola, 2006).

In another study done by Akintola (2010) called "*Unpaid HIV/AIDS Care, Gender and Poverty*" the writer discusses the amount of time put in by women in unpaid care work in the developing countries, caring for children, the elderly and the care for people living with HIV/AIDS which has increased time spent on unpaid care work. Akintola (2010) further discusses the prevailing poverty that burdens poor families who are forced to take care of their sick relatives more especially the women, further pointing to the fact that more time is spent on unpaid work than paid work thus the increased poverty. Akintola (ibid) goes on to discuss the costs for materials and care that befalls the affected families adding to the experienced poverty.

Orner (2006) conducted an in-depth study in South Africa amongst 45 caregivers, between the ages of 18 and 40 years old, and amongst them 43 were women. In consistency with other research done in South Africa on home-based care for people living with HIV/AIDS, the study

shows that the practical demands and constraints of the care work were often overwhelming (eg, Russell & Schneider, 2000; Dullabh,2003; Akintola, 2004) and elsewhere (UNAIDS, 2004). However, Orner's study further suggests that caregivers are often practically and emotionally weighed down by their care work despite the support they received and even where this support was considered helpful. Orner (2006) describes the caregiving process as "*placing considerable demands on caregivers at household level, negatively impacting on their mental health. Insufficient support, lack of income and dire poverty experiences*" (Orner, 2006). The writer recommends that the care and support of people living with HIV/AIDS should be integrated in the mental health services and community based care, integrate a gender perspective in the home-based/community-based care and support policy, strengthen the capacity of NGO's to manage the psychosocial and gender dimensions and lastly to develop the capacity of household caregivers who want training and learn from their experiences (Orner, 2006).

Lindsey, et al, (2003) conducted a study on "*Home-based care in Botswana: Experiences of older women and young girls* in 2002 amongst 35 care givers and 35 key informants from the government representatives and other stakeholders. The study was done as part of a larger research project funded by the World Health Organisation (WHO) with the goal to make recommendations and suggest strategies for developing and sustaining effective Community Home-Based Care (CHBC) in settings with poor resources. Their study in Botswana was carried out in three districts. The scholars' objective was to gain a greater understanding of the issues and concerns of family caregivers providing care in the home. The results of the study showed that the elderly caregivers experienced exhaustion from the overwhelming duties of caregiving which included collecting firewood, water, and laundry as most of the patients living with AIDS suffer from incontinence and chronic diarrhea, taking care of the orphans, cooking, the frequent visits to the health clinic etc. (Lindsey et al, 2003). Many of the caregivers did not follow the directions of using universal precautions for fear that their patient would be offended, thus escalating the risk of infection. The elderly caregivers also reported feeling depressed about the situation, personal neglect and malnourishment (ibid).

The younger girls reported that they lacked time to do their homework, experienced difficulties in concentrating at school due to exhaustion and malnourishment. The younger girls also reported that they are often socially isolated as they had no time to get out and be with their age mates.

The key informants reported that younger girls risk being infected with HIV due to sexual abuse from infected family members (Lindsey et al, 2003).

The prices of funerals were reported to be a major factor contributing to the experience of poverty apart from the fact that many of the breadwinners were too sick to work or had already died. Even the middle class families were afraid that they are slowly getting poor from paying for all the funerals (Lindsey et al, 2003). Other issues discussed in the study are the isolation experienced by caregivers, the stigma towards them and the lack of knowledge on HIV/AIDS, the need for psychosocial support for the caregivers and lastly the role played by the traditional witch doctors (ibid).

In a contradicting study, Akintola (2010) has recently done a study focusing on the advantages of caregiving experiences, comparing to a research conducted by Crook, et al, (2006) on the "*the experiences and benefits of volunteering in a community AIDS organisation* done in Ontario, Canada. The caregivers in Crooks study reported that they experienced rewards such as improved self-esteem and health, self-actualization, recognition, constructive feedback and participation in decision-making. In the context of Africa, Akintola conducted a study in the outskirts of Durban in South Africa among volunteers caring for people living with HIV/AIDS. The volunteers reported that they experience self-growth and personal and psychological growth, a feeling of being needed, learning good health behavior such as sexual behavior, appreciation by the patient and their family, giving pleasure to the patient and community members, acquiring skills and competencies to exercise in own family caring and a great reward and satisfaction in positive health for their patients (Akintola, 2010). Both Crook (2006) and Akintola's (2010) studies show many advantages experienced by the volunteers in caring for people suffering from AIDS-related sickness.

4 Theoretical Framework

4.1 The Social Role Theory

I present in this chapter the theoretical framework of the study. In societies, men have greater power and status than women and this often emerges in the control of women's sexuality and other aspects of behavior (Wood and Eagly, 2002). The social theory documents a series of social and social-psychological processes through which girls and boys acquire gendered subjectivity (Walby, 1990). This study has no intention of studying the causation of the different

gender roles of men and women in the society, but just point out that there are existing roles described to women and men according to their gender. These roles have existed for a long time, and differ across cultures to a certain extent, but have some factors in common. In agreement with the social constructionist theories (Mead, 1935), I argue here that gender roles are socially constructed. Mead (1935) argues that gender is constructed within cultures in response to the local situations and histories. The social constructionist also acknowledges the differences of roles described for men and women and the variation of sex roles as context related (Ibid). In this case the context of a rural area in a developing country in Africa South of Sahara. Furthermore the social constructionist point to the environmental factors such as culture and developmental experiences as shaping the social roles that we take on. I argue that social roles are embedded in the social cultural context and by placing men and women in different categories the social structure cultivates a process of sex-different behavior (Wood and Eagly, 2002).

Social psychologists further argue that the effects of relationships within and between groups of people such as how people behave in relationships and to them are the subject of social psychology (Hogg and Abrams, 2001). This also refers to the way people influence each other and how they react to the effects of social factors such as stereotyping, ideology and stigma. Communication is an important tool in social interactions both at the individual and group level as power relations arise from the use of language to give meaning to certain views of the world (DeVito, 2002). The social role theory gives emphasis to how we form and manage relationships in our social situations and the issues of identity in relations to matters such as stigma, group behavior, and the effects of environments, territory and material on social and personal change (Breakwell and Rowett, 1982).

The social role theory also has to do with the way people interact with others and how their expectations and reactions cause others to respond in a certain way. Howard and Johnson (1985) write about *the structural-functional role theory* that has to do with the positions that people occupy in social structures and the roles that are associated with the positions. Even referring to the roles as a set of expectations or behaviours that are associated with the particular positions and that affects the way people react to changes in life. Goffman (1968b) on the other hand writes of another role theory called the *dramaturgical role theory* that assumes roles as 'enactments' of the social expectations attached to a social status.

It is important to understand whether masculine and feminine identities are a result of a process of socialisation (Belotti, 1975; Comer 1974; Sharpe, 1976) as socialisation is considered to take place primarily during childhood, where boys and girls learn the appropriate behavior for their sex. Starting from the baby stage where little girls are given dolls in preparation for care later or groomed to help their mothers with domestic work while boys are out playing with their friends. These are examples of the stereotyped images of activities that contribute to expectations of the present and future gender roles which are also apparent in the media and add to the subordinated concept of the women. In the division of labour, women perform more domestic work than men and those who do enter the labour market spend fewer hours in paid employment and have lower wages than men (Ibid). In many societies and in Botswana women have less status, power and resource, leading to gender hierarchy in the social structure (Roodie, 1989). Gender roles are formed when each sex is expected to have characteristics that equip it for its sex-typical roles, therefore gender roles are shared expectations that apply to individuals on the basis of their socially identified sex (Eagly, Wood & Diekmann, 2000). These expectations act as normative pressures that foster behaviours consistent with sex-typical work roles. Although sex-different roles differs in cultures, a common factor across cultures is that status and power differences that are typically in favour of men do exist within societies and vary across societies (Leacock, 1978; Prato, 1996). Women are brought up to mother early in their childhood and although this is a rich experience, it also traps the women into unrewarded roles than men in contemporary society (Walby, 1990).

In Botswana, the traditional society expectations also play an important role on the family way of life. Women are taught from an early stage that care giving is their role in society and failure to fulfill that role is a disgrace both to the family and the society at large.

3.2.2 Feminist Standpoints

Situated knowledge

Feminist epistemology is used in studying dominating practices in the society that put women and other subordinated groups at a disadvantage. “*Dominant knowledge practices*” (Anderson, 2009) put the interest of women and subordinated groups at a disadvantage. Central to the Feminist epistemology is the concept of “situated knowledge”. This is the “knowledge that reflects the particular perspectives of the Subject” (Anderson, 2009). The Feminist Standpoint theory is one of the approaches used in looking at how gender situates subjects.

The Feminist Standpoint theory has its inspiration from Marxist epistemology, offering Feminist Standpoint theories a solid body to critique hegemony and a way to a variety of mediation (Haraway, 1998). The Feminist Standpoint theories claim “an epistemic privilege over the character of gender relations, and of the social and psychological phenomena in which gender is implicated, on behalf of the standpoint of women” (Anderson, 2009). As argued by Marxist feminists, the centrality of women in the reproductive system and care work in general makes them key informants in how patriarchy fails to meet the needs of the subordinated groups. As Harding (1993) puts it, the Feminist Standpoint theory is a tool that assists in helping produce oppositional and shared consciousness amongst the oppressed groups and in building these groups as collective subjects and not just mere objects of observation.

According to Harding (1993) the system of sex/gender is that of male dominance and is made possible by the dominance of women’s productive and reproductive labour and where “reproduction” is construed to include sexuality, family life and kinship formations as well as the birthing which biologically reproduces the species (Harding, 1993). This sex/gender system she explains comes in different intensities and forms, depending on the culture and the class. In interaction with different societal structures the sex/gender system is structured and so are the characters of the daily lives (ibid). Feminist Standpoint theories must therefore have a starting point “from the politically-activated perspective of the women in the division of the labour by sex/gender. For the standpoint to be fruitful in providing complete and less distorted information, it also needs to be sensitive to the differences as well as commonalities of women’s labour across “class, culture and race divisions” (ibid). Harding goes on to argue for an analytically impartial and epistemically non-relativist Feminist Standpoint that is able to understand sex and gender as an organic social variable which has become visible only because of the changes in historical relations.

The concept of situated knowledge as discussed by scholars such as Haraway (1998) is central to objectivity in Feminist Standpoint theory. Anderson (2009) writes that feminist objectivity allows theorists to become answerable for what they learn how to see as it is about limited location and situated knowledge. Harding argues that it is important to realise that objectivity is not “about transcendence and separating the subject and the object in order to get a clear understanding” (Harding, 1983). The Feminist Standpoint theory according to Anderson (2009) has the primary

function to empower the oppressed so that they are able to improve their situation. This is achieved by representation of the social world for the interest of the oppressed groups, supplying the information for the groups to enable them to understand their problems, and finally to supply the information for the subjects to use in improving their situation. In this way, the theory may offer true representations that are of more use to the women, hence claim to “privileged access to reality” (Ibid).

Discussion about objectivity among feminist scholars is directed towards the arguments that, objectivity claimed by scholars from the orthodox and social scientific disciplines reflects masculinist values and methods. This androcentrism, argued by Ho and Shrane (2004), was evident in the questions of study, the methods used in the studies, the criteria and the evaluating validity of knowledge claims. The androcentric definitions of the scientific and social scientific research has devalued the participation of female scholars and made it difficult for them to contribute to any change.

Objectivity in Feminist Standpoint is about positioned rationality achieved by challenging the patriarchal system and giving sight and voice to the oppressed groups by seeking situated knowledge made possible by communities (Haraway, 1998). The Feminist Standpoint acts therefore as a tool in expressing the experiences of women at a particular time and place within a particular social setting (Hekman, 1997). It allows theorists to see beyond the surface and reveal the “real” but concealed social relations. Feminist Standpoint theory has its strength in looking at the cultural location of the women’s oppression (Harding, 1997).

Anderson (2009) points out that Feminist Standpoint theory have the advantages in raising the central question about the justification that women have been and are oppressed. To me this is an important question and an eye-opener for the Botswana women that have been made to believe that their oppression by the male dominancy is a natural part of their daily lives. Another advantage is that of understanding that the knowledge is situated and perspective, and that this knowledge is produced from the oppressed standpoint.

However the Feminist Standpoint theory has its weaknesses and has been criticized for failing to provide a non-circular basis for deciding which standpoints have epistemic privilege, meaning that neither the standpoint of the women nor that of the third-world women can claim an

epistemic privilege (Anderson, 2009). Some critique has been based on grounding women's epistemology in their oppressions, pointing out that; "if the feminine ethics of care provides the epistemically privileged perspective on morality, then our access to moral knowledge is predicated on the continuation of existing gender relations which produce ethic" (ibid). We would therefore be forced to choose between ethical knowledge and living in a non-sexist society. Criticism is also that, no group inequality is central to all the others as the dimensions of inequality intersect in a complex way and therefore women would not hold the privilege of understanding their oppression. Oppression here, the critique continues, takes different forms for different women owing to their race, sexual orientation, etc. The critique is about the unified standpoint of the women as impossible because only the perspective of the privileged middle-class white women is in focus (Anderson, 2009).

3.2.3 Gendered Poverty

In order to reveal the complexity of poverty, recent studies suggest that qualitative methods enable an in-depth analysis of people's life worlds, their situations, their abilities and the opportunities to change their own situation (Lister, 2004). A qualitative approach can uncover meanings and provide us with insights on the experiences of poverty that are crucial to implications of poverty and are essential to implications for development and implementation of policies. Due to the moral imperative of poverty and its implications for the distribution, poverty is therefore a political concept but also social scientific (Lister, 2004). Furthermore, the visualization of poverty points out that these influences the ways in which poverty is understood by the society, especially by the powerful groups of the society rather than by those experiencing the poverty (ibid:4). Most researchers accept that definitions of poverty should be understood at least partly in relation to social, cultural and historical contexts. Thus, poverty has been defined in different ways; United Nations Development Programme (UNDP) defines poverty as "*...a denial of choices and opportunities for living a tolerable life*", while Sen (1992) argues that poverty should be defined in capabilities to reach certain minimal levels. The Copenhagen Declaration offers a combination of the "absolute" and "relative" notion of poverty leading; absolute poverty is characterized as "*severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health shelter, education and information*" and is related to "*access to social services as well as income* (UN, 1995: §19).

A rather limited idea on the concept of poverty is expressed by the World Bank; “*when estimating poverty worldwide, the same reference poverty line has to be used, and expressed in a common unit across countries*”. Therefore for the purpose of global aggregation and comparison, the World Bank uses reference lines set at \$1.25 and \$2 per day (2005 Purchasing Power Parity Terms). Using improved price data from the latest (2005) round of the International Comparison program, new poverty estimates released in August 2008 show that about 1.4 billion people in the developing world (one in four) were living on less than \$1.25 a day in 2005, down from 1.9 billion (one in two) in 1981. The new international poverty line of \$1.25 a day at 2005 prices is the mean of the national poverty lines for the 10-20 poorest countries of the world. While the revised estimate is significantly higher than earlier estimates of less than a Billion people living under \$1 a day in 1993 prices, the developing world as a whole remains on track to meet the first Millennium Development Goal to halve extreme poverty from its 1990 levels by 2015 (World bank website).

The main problem reflected by this definition, I argue, is not such the ‘dollar-a-day concept, but rather the way of seeing poverty as an absolute condition. Despite the fact that the most basic rights of a human being is naturally the right to life itself and the means of survival, the notion of absolute poverty includes ideological elements diminishing the meaning of economic inequalities in terms of material as well as the social and cultural conditions. Furthermore, a universal definition of absolute poverty ignores the structures of economic inequality in which poverty is rooted, constructing images of poverty in harmony with the theoretical conceptualization of the interconnection between economic growth and human development (World Development Report, 2000/2001). There is a great need of connecting poverty alleviation strategies to the politics of redistribution building on a liberal notion of justice that entitles every individual to a minimum level of life standard in their context.

Lister (2004) points to the fact that the definitions of poverty and its distribution have a general reflection on the individual and the structural perspectives. The individual perspective attributes the main responsibility for poverty to ‘the poor’ themselves and the structural to the economic, social and political structures and processes. Furthermore, economic dimensions are seen as ‘the order of nature’, which identifies poverty as an individual rather than a structural dilemma (ibid). In this way, symbolic dimensions of poverty have consequences for the ways in which poverty is

addressed in development work and at the same time affects the individual's perceptions and experiences of being poor. Lister (2004) emphasizes the discursive construction of 'the poor' as 'Other' to illustrate how 'the poor' are marginalized and treated as different from the rest of the society. Furthermore, in her argument that poverty cannot be understood in pure terms, Lister (2004) also puts emphasis on the need of understanding poverty as a social relation between 'the poor' and the 'non-poor' – a two way relationship: Whereby social processes such as stereotyping, stigmatization and categorization serve to portray 'the poor' as a homogenous group. The process of 'Othering' distinguishes 'us' from 'them' and helps to define the self and affirm identity of the 'non-poor'.

I here even argue that approaches to poverty also tend to exclude the different interests of people constituting the household where mainly male-household are the target and female-headed homes and women-maintained households are overlooked (Heyzer, 1994). Poverty faced by women is shaped by the interaction between gender, class and ethnicity and the unequal relations in the international and national economy. Women's experience of poverty differs to that of men due to the gender inequalities whereby they are entitled to fewer economic resources but greater responsibilities and less opportunities to make choices. Women bare greater responsibilities in domestic work and are the subject of the operations of strong gender hierarchies that results in unequal access to food, education, mobility, healthcare, information and therefore even less power (Heyzer, 1994). The poverty experienced by women is passed on to the children especially the girl child where they take on the domestic work and the maintenance of the household and more often are forced to drop out of school. It is therefore of imperative importance that poverty alleviation strategies, and governmental policies strengthens the women's claim to resources and access to information by including the women in decision-making and their experiences in implementation processes (Heyzer, 1994).

4 Research Methodology

According to Flick (2006), the topic of the study is the determining factor and the application of each method depends on its own characteristics and in line with epistemological and ontological standpoints. The choice of method is related to how appropriate or suitable it is for a particular type of problem (Malow, 2005).

In this chapter follows a presentation of the methods and measures of procedure of the study and epistemological, ontological and methodological concerns that guided the organization of and decisions during the fieldwork. The chapter is constructed in such a way as to bring into light the process of the conducted field work. The outline of the field work shall be presented in a way that should give the reader easy understanding, incorporating a discussion of implications and problems that arose in the field, including issues of reliability, validity and generalization according to the postmodern perspective (Kvale, 1997).

4.1 Research Strategy

This study has a hermeneutic approach, as understanding, interpretation and meaning are central in the problem formulated. The hermeneutic approach recognizes contextual knowledge as central for understanding (Gilje & Grimen, 2007). By interviewing HIV/AIDS next-of-kin caregivers, the social work department's representation, the HIV/AIDS programme coordinator in the Kweneng District and the public relations officer of NACA Botswana; I want to gain an understanding on the subject. What my informants tell me during the interviews is their own interpretations of their work; leading me to the interpretation of already described meanings in this study. According to the hermeneutic approach, we can never come closer to the research object without any kind of unbiased understanding (Gilje & Grimen, 2003) and our pre-understanding is built on experiences, lessons learnt and feelings. These prior understandings make it difficult to accomplish total neutrality in the study, but consciousness of this makes it easier to act carefully while interpreting and presenting the pre-understanding (Ibid, 2003).

4.1.1 Pre-conceptions

To be able to understand what the interviews bring forward without risking to misinterpret what the informants tell me, I have to be able to recognize my own preconceptions and assumptions. Self-awareness creates space to separate the researcher's thoughts from the interviewee's thoughts and feelings (Ely, 1993). I have an experience of relatives terminally sick with AIDS and in need of care. This care was given by my mother and her younger sister. My understanding of AIDS caregiving is based on previous research, internet, and what the media brings forward. My experience of giving care to AIDS patients is that it can be psychologically and physically challenging for the caregiver. My mother who had a job at the time had to take leave of absence from her job, which meant that she would not get paid for the months that she was home giving care to her sick son. She is one of the few people that could afford to do this, but many that lack

the means of support are also in the same 'boat'. In this context next-of-kin caregivers for HIV/AIDS patients should give care to their sick relatives as well as trying to find means of financial support.

My experience is also that caregiving of HIV/AIDS patients is completely taken on by women as traditionally has been the case with all kinds of care work. In the cities there are some groups of Hospice created by big religious organizations. The Hospice personnel visit HIV/AIDS patients in their homes now and then offering help with feeding and/or bathing the patients. The health care clinic nurses also offer some home visits to deliver such articles as gloves, paper sheets, nappies and general advice. My understanding is that the poor, uneducated women in the rural areas who are working as our domestic workers are also forced to leave their jobs to care for their sick relatives. There are no such hospice organizations in rural Botswana, and my understanding is that there are long distances between the areas to be visited by the health care personnel. According to Bryman (2008), if the researcher exaggerates her own experiences this can lead to missing out on important information. It is therefore important to discuss my understanding for the interpretations of the material. I am aware that I have to control my preconceptions so that they are not allowed to meddle in the interpretations work.

4.1.2 Qualitative Methods

In this study I have chosen the use of qualitative methods to create a deeper understanding of the experiences of AIDS caregivers in rural Botswana. Qualitative research originates in hermeneutic interpretations and puts emphasis on the understanding of a persons' interpretations of their social reality (Bryman, 2008). Even though qualitative methods have been traditionally criticized for being too concerned with subjectivity, for being difficult to replicate and being problematic to generalize (Bryman, 2004), they do carry a sense of flexibility that is necessary for answering this study's research questions. Alvesson and Sköldberg (2008) recommend that these aspects of replicacy or generalisability are not always relevant or productive for research. Qualitative research is often used in describing social phenomena, processes and relations and is of specific relevance to the study of social relations, weighing to the fact of the 'pluralization' of life worlds (Flick, 2006). By choosing the use of qualitative methods I am able to interact with the participants in my study and give them a chance to share their experiences in a way that is otherwise impossible to do. This way, the caregivers get a chance to voice their experiences in the roles of unpaid AIDS care work, for me to understand the experiences, their roles and

standpoints in their daily work. As Beck, 1992 (cited in Flick, 2006) emphasizes; these ‘pluralizations’, are the growing individualization of ways of living and as such require a new understanding to the empirical study of issues.

Fieldwork forms an alternative to quantitative methods and provides an opportunity to give new perspectives on old ‘truths’ (Reinharz, 1992). In comparison with conventional field methods, feminist field researchers stress “...*the necessity of continuously and reflexively attending to the significance of gender as a basic of all social life and... understanding the social realities of women as actors* whom previous sociological research has rendered invisible (DiIorio, Judith cited in Reinhartz, 1992). My study was formed through the conscious choice of a participatory approach including semi-structured interviews which seek to give knowledge, understanding and insight into the experiences of women next-of-kin caregivers of patients with AIDS related sicknesses in rural Botswana, knowledge formulated through my understanding of these women’s situation.

To involve the reader in the process of creating knowledge, feminist scholars stress the importance of revealing possible obstacles and constraints in the research (Reinharz, 1992). The process entails describing precisely what takes place during the collecting of data and during the analysis process, even showing a self-reflexive reporting of the work conducted in the field. The results of the study are a combined product of writings about the self, the group studied and the relationship between the two. Flick (2006) contends; the subjectivity of the researcher and the researched becomes part of the research process. With the aim to obtain an in-depth understanding of the women’s standpoints in the society and to get their perspective I chose to conduct a qualitative research. My focus in this study is to give space and voice to women usually not heard in development discussions.

4.1.3 Target Samples

4.1.3.1 Selection of Informants

Selection of informants is one of the significant tasks in qualitative research. Selecting the participants who will give the right information answering the research question has often been a difficult task for many researchers. For this study selecting informants it was crucial for me to choose persons having the necessary knowledge useful and even more, that these persons are able to express themselves in a way that, I can understand. These considerations are very important

because if the researcher does not choose the person with the right information, then data can be misleading or fail to answer the research question (Kvale, 1997). Purposive sampling is therefore applied in this study in choosing the people who have the relevant information to the research topic. According to Bryman (2008) purposive sampling is essentially strategic and entails an attempt to establish good correspondence between research questions and sampling. Flick (2006) argues that, when choosing an informant, it is important to reflect upon how to use and analyse the information collected. This kind of sampling allows me to intentionally select the elements that are rich with information (Marlow, 2005). These key informants are the Public Relations Officer at NACA, the organization responsible for facilitating work against HIV/AIDS in the whole country working hand in hand with HIV/AIDS Programme coordinators in the different districts at the implementation stage whom in turn work together with the Social Work departments in the districts, hence the Deputy Chief of Social Work Department in Kweneng District, a key informant (Marlow, 2005). While interviewing these key-informants the aim was to gather information about the HIV/AIDS organization in Botswana, which is a very big organization with different organs. But mostly I was interested in gathering information about patient care and the organization behind it, but even get a view of the supportive structures that the government has set up after the passing of the HBC policy, mainly directed at the caregivers of people with AIDS related sickness and their patients.

Before I left Lund, Sweden to conduct my study in Botswana, my intention was to contact the caregivers that I already knew and have contact with in Molepolole, a town where my mother lives. However, in my arrival there, I was introduced to many different people working with HIV/AIDS one way or the other. I decided that since I have been away from Botswana for a long time, I should strive to gain more information on the HIV/AIDS programme in Botswana and the Home-Based care policy, also looking for information on who was responsible for what and for whom. Hoping to gain information on the background of the work against HIV/AIDS, I decided to get into contact with NACA's public relations officer. With much luck he agreed to meet me the following morning.

After our meeting NACA's public relations officer advised me to book a meeting with the officer in charge of implementation of HIV/AIDS programme, the HIV/AIDS programme coordinator for a further clarification of HIV/AIDS work at the district level. The HIV/AIDS coordinator further recommended that I meet up with the deputy chief Social work in the district as they are more knowledgeable in the implementation at grass-root level.

I was introduced to a woman, active in development work in Moshaweng. This woman it turned out she has the experience of caregiving for a passed on relative who had died from AIDS. The woman is also active in processes of empowerment for women of the minority in rural areas, especially in Moshaweng where she was born. Thereafter in a meeting with Irene I learnt that there was a group of women who were working as next-of-kin caregivers for PLWHA in Moshaweng where Irene has been the council representative for the ruling Botswana Democratic Party for some years. Irene also told me about a plan to build an association with the objectives of starting up a day-care center for AIDS orphans in Moshaweng. As a previous caregiver herself, Irene thought it was important for the caregivers to form some kind of association where they would help each other in their daily lives and work. The association is to be built by a number of women who are taking care of relatives living with HIV/AIDS, and get access to funds from the HIV/AIDS programme to care for the AIDS orphans in the village which would even give the caregivers some kind of economic support and emotional support for each other. I decided there that this was the best population for my study because while some of them had the experience of caregiving for PLWHA some of them were still working as next-of-kin caregivers for PLWHA. This was for me the best group of caregivers to interview as they had the first-hand experience of giving care for their relatives. It was also easier for me as the caregivers had already formed a group which would in turn give me access to a ready-made group of interviewees and would make it easier for me to get access to the information, and they were also part of the up-coming association to be built which to me was a symbol of the awareness of self-help and trial at empowerment processes. I realized studying a group of caregivers belonging to one of the minority groups in rural Botswana would be more interesting for my study as these women probably have difficulties in accessing their rights in the society than any other groups, due to their status.

With Irene's help I was able to explain the aim of my study and even gain the women's trust which is very important for me, especially when researching such a sensitive and stigmatised subject as HIV/AIDS care. In a meeting with the women before my interviews with them, Irene introduced me to the women and explained about my research. All of the women in the group decided that they wanted to tell their story. It turned out that many women who heard about my study wanted to participate, however my criteria was set to interviews with women who have given care to next-of-kin with HIV/AIDS related sicknesses.

4.1.3.2 Bakgalagadi in Moshaweng

Moshaweng is a little village in the North-West of Botswana, in the Kweneng District and the population in Moshaweng is highly concentrated by people of the minority tribe called the Bakgalagadi. The women I interviewed belong to the Bakgalagadi tribe. For decades this group of people has worked as farm help and domestic help in Batswana homes and has had little or no rights to be in school like the rest of us. Nowadays many of these people are highly educated, but many remain uneducated and poor, especially the women some still working the farms and others working as domestic help. It is however important to note that the study focuses on women in rural Botswana as next-of-kin caregivers and not on tribal belonging. I interviewed 8 women caregivers, and some of them have been to school, but dropped out at grade 4, while the rest have never been to school at all. None of the women could understand any English so all the interviews were conducted in Setswana, which was still easy for me to do as I speak the language.

Looking back at that time I realize that I was lucky to have met with Irene because without her help I would probably have had difficulties in recruiting such a group to participate in the study. But since Irene was one of them, acting as their leader and could introduce me as not being harmful to the group in any way, the women accepted me amongst them. At the time of interviews the association was in the development stage, but had come as far as the actual planning of the opening of the day-care center. The association had found a deserted house in the village that was believed to be haunted and were actually given permission to use the house by the chief of the village.

The next stage was to book time for interviews with the caregivers in their village Moshaweng. This I did with Irene's help who went back to the women, as none of them had telephones and negotiated a time that would suit them for interviews. Everybody agreed that it would be easier for me to come to Moshaweng on a Friday when they are all at the local clinic either to accompany their patients or are themselves queuing for the antiviral medicine. The chief of the health clinic had prepared one of the offices for us to use as an interview room. Two of the women were in her home, a short drive from the health clinic.

4.1.3.3 Key-informants

In the effort to gather background information on the HIV/AIDS programme in Botswana, I interviewed three key-informants. I started by booking a meeting with the Public relations officer at NACA. Their offices are located in Gaborone, the capital city. This interview lasted for an hour and finished with a tour of the organisation's library. The public relations officer at NACA gave me background information of NACA in the facilitation part, which is important in the formulation of my interviews with the caregivers. He further pointed out the importance of the district HIV/AIDS coordinating officer in the equation of the work against HIV/AIDS. I therefore booked a meeting with the HIV/AIDS programme coordinator in Kweneng district, in order to gain more insight in the implementation part of the work against HIV/AIDS with focus on the kind of assistance provided to next-of-kin caregivers and the patients. This interview was conducted at her office in Molepolole where she informed me of her work in working together with social workers to fulfill the implementation part of the work against HIV/AIDS. She further referred me to the deputy chief of social work department in the district. Her office was quiet close to the coordinator's office, so she accompanied me there and introduced me. I told her about my work and asked her if she would be willing to answer a few questions in regard to my study. The deputy chief of social work was delighted and positive; she accepted and gave me useful information that I used as the basis of the interviews with the caregivers.

4.1.3.4 Caregivers

After the interviews with the key-informants I formulated the interview guide with the basis of the information gained from the interviews with the key-informants. I then took contact with the leader of the group Irene to help me book time with the caregivers for interviews. We started our journey from the neighbouring town Molepolole, early Friday morning so that we were in

Moshaweng already by 10:00 in the morning. The sun was already shining and hot by the time we arrived at the village health facility where many people had gathered and were queuing for their monthly checkups or just for minor medical attention. When we arrived in Moshaweng that Friday, the chief of the health center had reserved an interview room for our use. It was a sunny day and the whole yard was full of people, some lying under the shadows of the two Jacaranda trees while others sat under the shadow of the house. Six of the women caregivers were already waiting for us at the health center while the other two had sent messages with the others that we were welcome to come to their homes to interview them. These interviews lasted for about 20 to 35 minutes.

In a way I gained the trust of the caregivers from the beginning and they were eager to talk to me. This could depend on the fact that I appeared at the health center in the company of their 'leader', dressed in the traditional dress and speaking their language. I accompanied them one by one into the interview room for interviews, and afterwards we visited the homes of the other two and carried out the interviews in the comfort of their homes. However in the interview situation, the women were not very 'open' to deeper discussions. Many of the questions were answered with a short 'yes' or 'no'. Having grown up in the Botswana society, it was easy for me to read on the women's faces when they decided that the answer was enough and they will not offer more. I decided that it was important for me to respect their decisions and move on to the next question so there was less probing in the questioning.

In my perspective, the material gathered from the interviews is important to show the experiences of the next-of-kin caregivers in the daily work, even giving light to the lack of support from the government in the caregiving work. I realize that being able to speak the local language was an advantage in my part not only because of the language but, also because of the ability to read the body language that is special for Batswana. I believe that conducting interviews is the best way to understand experiences and give space to the voice of the participants which even is the best way to answer this study's research questions. The interviews were only conducted in Setswana and recorded in their originality, later transcribed into English and coded into different themes.

4.2 Data Collection

4.2.1 Preparatory work

When preparing for the study, I put a lot of work in reading with the aim to gather as much facts as possible about HBC Policy and caregiving of HIV/AIDS patients in Southern Africa and especially in Botswana. I have also tried to find all new information reports on Botswana, on the World Bank, UNIFERM and the UN since I left the country a few years ago. However a lot of my reading was focused on increasing my knowledge in preparation for interviews, with the ambition to understand the experiences of the next-of-kin caregivers in their daily work. I have kept it in mind that interviews like any other social meeting, age, gender, ethnicity, class and other factors are influential of the situation (May, 2006). I am aware that the researcher's choices are influenced by her interests and interpretations of the material is affected by the researcher's subjective evaluations and inputs (Bryman, 2008). Since I have experience of caregiving for AIDS patients, I understand that it is difficult to be totally neutral in the analysis process, which makes it more important for me and the reader to be aware of this. However, I see my preconceptions as a kind of resource in the study and have chosen to present this articulately (Descombe, 2000).

The day before the interviews with the caregivers in Moshaweng I properly prepared the clothing that I decided was proper to wear to such an important meeting. I was dressed in the traditional dress 'leteishe' which is worn by all women mostly in traditional festivities, and that is also be seen as a humble dress when embarking in the field. This was important to do as even though I am 'one of them', meaning that I am from Botswana and from the same district, I still belong to another class and live abroad. As feminist scholars point out, it is therefore important for me to fit in.

4.2.2 Interview situation

I chose to conduct semi-structured interviews based on particular themes and questions, with the purpose to give the informants possibilities to speak freely about the subject, and with room for developing and clarifying their answers. Semi-structured interviews tend to give answers a deeper meaning and find possibilities of new interesting aspects to the subject (May, 2001). The advantage with this form of interviews is that the researcher can come closer in to the reasoning and the feelings that come up with the interview (Kvale, 2006). This form of interview also

contributes to an understanding of the informants' thoughts and not what I as the researcher think they think. This means that I have the possibility to find out new things that I did not think of from the beginning (Ruane, 2006).

4.3 Limitations and Technicalities

During the interview the respondent is required to demonstrate their competence. However sometimes some of the difficulties that I faced during my interviews was that the women did not have a concept of the interview, they did not share the concept of the propriety of talking about themselves and their caregiving. I realize that while semi-structured interviews served as a useful tool in obtaining the material for this study, it also has its limitations. I felt that the caregivers did not feel free enough to continue to answer. Unlike participatory fieldwork where I would meet the women on a few occasions before I get down to the interview part, therefore giving them a chance to know me and for me to know them. However, the limitation of the semi-structured interviews was compensated by the fact that I turned up for the interviews with one of them, the leader of the group and speaking their language. In this study the interviews with the women are presented as interviewee 1- interviewee 8.

4.4 Ethical considerations

The question of ethics is important to consider from the planning of the study to the end so as not to affect the study population adversely. Already at the problem-formulation stage, the ethical problem and how they can be dealt with need to be examined (Cargan, 2007). HIV/AIDS is still a much stigmatized disease especially in the rural areas where most of the people have low education and have less access to the latest research and information. However, I do not see any harm in speaking to the HIV/AIDS next-of-kin caregivers as my aim is to find out how they reason around my research question on their important daily work. I have no intentions whatsoever of probing in their private life. I do however understand that it can sometimes be delicate for my informants to engage in deeper discussions as their work regards a stigmatized disease in their homes, but also realize that the study does not pose any psychological or physical damage for them. My judgment is therefore that even my analysis is ethical (Cargan, 2007). To address the problems of consent, decision making, anonymity, integrity and confidentiality I informed the participants about the study, how I shall treat the information I receive from them and received therefore consent from all the informants. The information I gathered from the

interviews shall only be used in the study and shall be handled with the utmost confidentiality where the informants anonymity is respected (Marlow, 2005). I made sure that every interviewee understood that they had every right to discontinue with the interview at any time and that they did not have to answer the questions that they did not feel comfortable answering. Due to the sensitivity of the subject, I made sure that I approached the interviewees with respect where I refrained from probing further if they did not offer more information regarding the question asked. This I did consciously so as not to invade the participants privacy (Bryman, 2008).

When entering the lives of the study's participants, the researcher needs to guarantee their dignity and rights by getting their voluntary consent. Definite confidentiality is also an important aspect in the process of research for the participants (Flick, 2006). Preceding my interviews I was given consent by the interviewees and explained that all the information that comes forward during the interviews shall only be used for the purpose of the study. The researcher undeniably meets with several unexpected dilemmas and makes choices that determine the outcome of her study. Building of trust can be problematic in the relationship between the researcher and the researched and problems could arise caused by differences in socio-economic status, ethnicity and class. Trust has to be earned, especially when a woman is studying other women and to be able to gain access of the views of a diverse range of women, the obstacles that could be brought upon by differences should be overcome (Reinharz, 1992). Regarding closeness/distance, Reinharz (1992) points out that for the sake of increased objectivity, the researcher must maintain a distance to avoid 'going native' or identify with the people studied. However, many feminist researchers emphasize the importance of the researcher's closeness with the women, even claiming that it is essential for better understanding.

4.5 Reliability of the Study

When setting out on this research my ambition was to try and understand how women caring for relatives suffering from AIDS related sickness reason around their care-work under the home based care policy and what measures the government has taken in supporting the caregivers and their patients, without jumping to any premature conclusions. Since the HIV/AIDS pandemic has added to the amount of unpaid care work for women, this is to me an interesting subject that has to be revisited. I see the importance of qualitative method in the form of semi-structured interviews, as the best tool possible of gaining this knowledge from the caregivers themselves.

However, during the interviews I realised that there were some reservations on the part of the caregivers in speaking freely about their lives, and this could raise a question of the study's reliability. This should however not pose any reliability harm to the study as the main aim is to tell the story of the next-of-kin caregivers. I insist that a new study would give the same results. From this perspective, the study has a high reliability (Bryman, 2002). I see my position as an interviewer advantageous in the sense that, we speak the same language and understand the body language that is special for Batswana, therefore there was no need for a translator and the risk of losing important information was narrowed. This study has no ambition of showing a general picture of how it is for all next-of-kin caregivers for patients with HIV/AIDS related sicknesses, but how it can look like for some of them, especially in the rural areas of developing countries like in this case Moshaweng in Botswana.

5 Research Findings & Analysis

In this section I shall present and analyse the findings of the study using the theoretical framework. The researcher's analysis of the empery is an ongoing process and starts when entering the field. To establish what is happening in the field and to be able to make relevant interpretations of events taking place in a specific area a wide theoretical foundation is required, and knowledge about history, political situation and cultural codes are to be taken into account in the process of interpretation (Bryman, 2008). To answer the study's research questions I shall analyse how the women themselves experience their situation and make use of the information provided by the key informants on the social and health services provided to next-of-kin caregivers and the people living with HIV/AIDS in Botswana. I should here even mention that the interviews with the key-informants was merely used as a way to inform me the interviewer about the availability or unavailability of the HIV/AIDS organization in Botswana and the governmental support structures set up with the passing of the HBC policy. I shall then go on to analyse the eight semi-structured interviews with the next-of-kin caregivers.

In analysing these interviews I shall employ the use of qualitative content analysis. By using the qualitative content analysis I gain the advantage of easily combining empery and theories of the study (Flick, 2006). Holsti (1969; cited in Cargan, 2007) contends qualitative content analysis is a method whereby "*making inferences by systematically and objectively identifying special characteristics of messages*". This statement is in agreement with Flick (2006) where he claims

that the qualitative content analysis is a way of reducing the empery by categorising with the use of applied theories. Furthermore, the use of categories is an important feature of this method whereby the contents of the interviews are coded and the inferences are made based on the incidence of the codes (Marlow, 2005). Emphasis is based on description rather than on the relationships between the categories and themes (ibid; 223).

The steps of analysing the interview material according to Kvale (1996) are interpretation, condensation and categorization of meaning and narrative structuring. Flick (2006) on the other hand mentions three main techniques in content analysis which are; summarising, explicative and structuring. To be able to see the different angles of the interview material, I shall employ the different techniques mentioned by the two scholars, which will even contribute to seeing beyond the structure of the manifest meanings of the text (Kvale, 1996). With the help of the techniques of interpretation, condensation and categorization of meaning I shall structure the interview material from transcripts according to themes and describe these consistently.

As the aim of the study is to give voice to the women burdened by poverty, unpaid care work for AIDS patients and the traditional unpaid family care work. I shall focus on analysing the interviews with caregivers and add on the information given by the key-informants. I shall start the section by presenting the findings of the study, beginning with the information given by the three key-informants and moving on to present the results of the interviews with the 8 caregivers and analyse these accordingly. To make it easier for the reader I shall present the findings under themes and analyse the findings with the study's theoretical framework to answer the research questions.

5.1 The role of the state in support for caregivers of people living with HIV/AIDS

5.1.1 Social Policies, Health Care Policies and the Home-Based Care Policy

With the aim to give light to the role played by the state in the effort to assist caregivers of patients of AIDS-related illnesses, I will show the existence or non-existens of supportive structures built into social welfare system aimed at caregivers in Botswana and rural Botswana. I shall present the 3 semi-structured interviews with the Public Relations officer at NACA

Botswana and the official website of NACA Botswana, the interview with HIV/AIDS coordinator in Kweneng district and the interview with the Deputy Chief of Social Work department in Kweneng district.

Firstly it is important to remember that in Botswana due to the impact on the Health services caused by the great number of people infected with HIV/AIDS, the HBC policy was passed as a way to relieve the health care system as it was having difficulties coping financially and there were not enough hospital-beds to accommodate all the sick people. With this policy, care for people living with HIV/AIDS was instead passed over to relatives. I find it therefore imperative so find out if there is any assistance directed by the state towards the caregiving relatives.

NACA Botswana is the facilitating organ for all the projects that are directed in the fight against HIV/AIDS. These projects could be directed towards AIDS orphans or for teaching the people about HIV/AIDS, etc. It is through NACA that all the donations coming from other countries to Botswana aimed at HIV/AIDS are handled. NACA in turn works hand in hand with the HIV/AIDS coordinators at district level, whereby all applications of funding for HIV/AIDS related projects are handed in and dealt with. The coordinators are then responsible for the selection of the projects viable for funding, in accordance with the yearly themes stipulated by NACA Botswana.

At the HIV/AIDS coordination level, the coordinator is firstly responsible for deciding on the projects to be funded and then to monitor the projects during their lifespan. The HIV/AIDS coordinator also works hand in hand with the district social work department. During the interview, the coordinator mentioned that every year there are many projects dedicated in helping in the HIV/AIDS struggle in the country. These may involve daycare centers for orphans or building houses for orphans or teaching people how to avoid contracting the HIV.

In Botswana people regarded as destitute, and orphans receive monthly coupons for food and school uniforms. New mothers diagnosed with HIV/AIDS are advised not to breastfeed and instead are given milk substitute to give to the newborn baby. According to the Deputy Chief of social work in the district, there are not enough resources to employ enough social workers to carry out the workload. This means that the social workers in the district are having problems attending to all the cases that need attention and reaching the people in need of social work

resources. The other problem mentioned is that the social work department lacks the financial resources to purchase vehicles for transporting the social workers throughout the district to get to the people in need of help.

During the interview, the deputy chief of social work department also mentions that there is a problem of specialization in the social work education at the University of Botswana. The training of social workers is based on case work, not on specializing on different social problems in the society, this she sees as a problem when it comes to working in the field and sees it as one of the causes of the problems of professionalisation of the social work profession in the country. She goes on to add that the social work profession is looked down upon, leading to less people wanting to work as social workers, hence the shortage of social workers in the country. The other problem brought forward in the social system in Botswana is the lack of proper systems of accessing information on the people in need of social resources, mentioning even that the only way of accessing this information is through the contact with the clinics, the hospitals and the police. However the problem stays on as the people themselves are not aware of this system and therefore do not take report their needs to any of these places mentioned.

5.2 The caregivers' experiences of the social services' interventions

I shall here go on to show the results of the caregivers' experiences of the social services' interventions in their daily work, and move on to show the results of their experiences of the health care services. During the interviews with the caregivers in Moshaweng in the Kweneng district in Botswana, seven of the eight women mentioned that they have had no contact with the social services and had no economic support whatsoever for staying at home and caring for their sick relatives instead of working. The one that has some kind of contact with the social work department is caring for the AIDS patient and some of her orphaned grandchildren, and the AIDS orphans receive coupons every month-end. The caregivers reported that they didn't know where to get hold of the social worker and the impression is that there is lack of trust in the state when one of the caregivers says.

Social workers! I don't know where to find them and [...] anyway, they will refuse. I heard they refused to help one woman who asked for help, they told her to look for a job (interviewee 2)

[...] n...no miss, as I told you, it's only my mother who helps us with food when he's sick and I can't leave him to take piece-jobs. I haven't seen anybody from the council or any social worker. [...]...the only people that give us support are the neighbours. They do bring us a bag of sorghum or beans during the harvesting period. The thing is in Botswana it's only some people who get the food for poor people (interviewee 4)

As the two quotations indicate the next-of-kin caregivers are left to fend for themselves with the sick relatives. Furthermore despite the fact that the HBC policy was introduced by the government and imposed on the caregivers there are no established contacts with the social workers in rural Moshaweng. Not only do the caregivers lack established networks with the social workers, but they do not have the information on how to get hold of the social services in case they really need to. The extended family and the neighbors play an important role in supporting the caregiver who cannot go out and get a job to support the family any longer. The caregivers' statements are in conjunction with what the deputy chief of Social Work department said; that there are no proper systems on how to reach the people in need of social work resources, that there is shortage of social workers to cover the whole district and no vehicles to transport the available social workers. Most importantly, there are no set resources targeted at next-of-kin caregivers of people with HIV/AIDS or their sick patients from the social work department. I emphasize that it is important for the government to address the vulnerability of poor households and communities. Resources have to be put forward to alleviate the social and economic impacts of the policies that have been introduced by the state due to HIV/AIDS pandemic on the lives of the affected households. There is an urgent need to address the provisions of services to poor households coping with HIV/AIDS, taking into consideration the gender dynamics and dimensions and the implications of the care burden on preventions and poverty eradication.

Even though the caregivers were poor in the beginning of the caregiving work, they have become poorer. As Lister (2004:35) points out, the definition and distribution of poverty has a reflection on the individual and the structural perspectives. Due to insufficient support from the society and lack of income, the next-of-kin caregivers are weighed down by their work and end up in dire poverty with the rest of the family (Orner, 2006).

Better understanding of the situation of the next-of-kin caregivers through research may reveal the complexity of poverty. Recent studies suggest that qualitative methods enable in-depth analysis of people's life worlds, their situations, their abilities and the opportunities to change their own situation. A qualitative approach can uncover meanings and provide us with insights on the experiences of poverty that are crucial to implications of poverty that are crucial to implications for development of policies. Due to the moral imperative of poverty and its implications for the distribution, poverty is therefore a political concept but also social scientific (Lister, 2004). Furthermore, the visualization of poverty also points out that these influences the ways in which it is understood by the ways in which it is understood by the society, especially by the powerful groups of the society rather than by those experiencing it. This interviewee below tells a sad story and says;

No...Miss, the only thing was for me to take him to the hospitals...it's only the hospitals...he was living far away in Orapa working when he became sick. But I ended having to remove him from there because there was no... they were not giving me any help so much so that I ended up having to hire a lorry to transport him home. Because of this lorry I ended up in court after he died and had to sell my last cow to pay the owner of the lorry... The hospital was not of any help at all...even when I told them that "this man cannot stay here as sick as he is, because his parents are far away in Moshaweng and we are here...here in Orapa. [sigh]...Couldn't you transport him with the council car for me to Moshaweng?" ...No...no...they ignored me [sigh]...ignored me until I was forced to hire somebody's lorry, not even thinking about how I intended paying for it, so much that after he died the man took me to court in Letlhakane and I ended up having to sell the last cow [sigh]...which was really supposed to be kept for the child... I paid that man. (Interviewee 1).

She ended up in that difficult situation where she needed help to transport her sick husband from a faraway town to the village where she lives for her to give proper care in his last days. Not even then would the social services or the health services help her solve this problem. She ended up having to take the last of what would help pay to raise their child to pay for the transportation, after ending up in court for owing the owner of the vehicle. This woman continued to struggle to support her child after the death of her husband. There is an increasing urgent need for social protection benefits to compensate for the loss of income in Botswana, particularly for the women and girls. Apparently even the contact between the social department and the health care is not

that established so much that even a terminally sick person cannot be transported by the ambulance from one place to the other. These families are being denied the choices and opportunities for living a tolerable life (UNDP).

I was left to struggle with my son, who was at the year old...I struggled with him having no means to support him, and eventually in the end I was forced to leave him with my mother to go and seek work as a domestic worker, and worked there...[sigh]...but also the problem is that it is difficult to work as a domestic worker when you become as old as I am, more especially that I have a home, and being away for too long the home becomes deserted and the thatched roof may fall in when I'm not there...[sigh]...So I came back when my child was to start school so that I can be here so that he can go to school...because the old lady lives out in the farms (interviewee 1).

To support her son, she had to leave him with her mother and seek work far from home, but even this did not work due to her age and to be able to put her son in school and secure a better future for him. Costs for materials and care, and later on funerals have driven many families to extreme poverty, while some caregivers tend to neglect themselves while giving care and end up malnourished and isolated from the rest of the society (Lindsey, et. al, 2003).

As orphans are entitled to monthly coupons that allows them to eat and buy school uniform, some caregivers living with orphans can manage to feed the rest of the family through the coupon system. One of the caregiver reported on having contact with the social services because apart from caring for the AIDS patient, she is also responsible for the care of orphans left behind by relatives due to AIDS. However, even those that have contact with the social services do not give a positive impression of the state's resources or the social services as an organ.

[Pause] my child, if it wasn't for the orphan food that these children are getting from the council, I don't know [sigh] how I would provide for them. They get enough food to feed us all [pause] and that's good [pause] because I can't work anymore (interviewee 6)

[sigh] money [pause] money is a problem miss...my mother helps us sometimes when she gets her food basket from the social workers, and like [pause] like last week, then his sister came to stay with him because they called me to help them to weed their yard [pause] the people that I help with household chores, I mean (interviewee 4)

5.1.2 Knowledge of the Home-Based Care Policy by the Caregivers

The impression given by the interviewees is that none of them really know what HBC policy means or what it entails. Their understanding is that they now have to take more responsibility in the care of their loved ones in their AIDS-related sickness because there are too many sick people in the whole country for the hospitals to occupy. The people lack the knowledge that this is a policy that was passed by the state and that they are now expected to do this care work whether or not they can or want. When I ask the question if they know what home-based care policy is, my understanding is that they refer to the community home-based care. The community home-based care are groups of volunteers that have decided to come together to support caregivers in their work. These kinds of groups, if organised properly may get economic support from the district HIV/AIDS coordinator. These groups of volunteers known as the community home-based care are more organised in the big towns and in the city, but none exist in the small villages like Moshaweng. The answers given by some of the caregivers are as follows:

Yes, I have heard that they have that in places like Molepolole, but I have never heard of any in Moshaweng (interviewee 1).

Ah...I heard some people talking about it, that in Molepolole they have come together and formed associations to help each other to take care of patients (interviewee 2).

That woman who brought you here [pause] she told us about that kind of thing. [Pause] she is trying to get us together to form something like that [pause] but I'm not sure. When I met her on Wednesday she was talking about that. She was going to tell the others [pause] yes, she wants us to start a group to take care of the orphans [pause] help each other with the patients (interviewee 6).

In the last quotation by interviewee 6, the woman being referred to is the former counselor in the village who is looking into acquiring funds from the HIV/AIDS coordinating office to start-up a group formed by caregivers. This group, she is planning will take care of the village's orphans and at the same time act as a supporting hand for each other in their caregiving work.

The home-based care policy is an example of dominating practices that Anderson (2009) refers to that put women and other subordinated groups at a disadvantage. The HBC policy was introduced in Botswana by politicians without informing the citizens of the burdens they will have to carry. As Marxist feminist argue, the centrality of women in the production system and care work in

general makes them key informants in how patriarchy fails to meet the needs of subordinated groups (Anderson, 2009). In my opinion, the experiences of the women as the main bearers of caregiving that could help in creating awareness regarding the essence of their knowledge is always excluded from research and policies. The women are exploited into taking on more care work without their knowledge as whereby womanhood is connected to family caring and is understood as a social responsibility where women are expected and expect themselves to be the sole caregiver (Sandberg, et, al, 2009). It is not so unlikely that the next-of-kin caregivers have no knowledge of the HBC policy as the packaging of information is not user friendly and is not presented in a manner that targets the illiterate people (Women's Affairs Department, 2003: 33). The way that the policies are imposed on illiterate people, especially women points to what Harding (1993) calls the system of sex/gender of male dominance and which is made possible by the dominance of women's productive and reproductive labour, and where "reproduction" is construed to include sexuality, family life and kinship formation. Such policies are made up at the political level by men for the women. There is a need to supply information for the subordinated groups to enable them to understand their problems, and finally to supply them with the information they need to improve their situation (Anderson, 2009). The government is responsible of making sure that all the citizens understand what implications the introduced policies carry for them, and an even greater need to evaluate the implementation of these policies to realize their gendered nature which are oppressive to women. This way the patriarchal system will be challenged and give sight and voice to the oppressed group through seeking situated knowledge (Haraway, 1988: 590) To challenge this patriarchal system the feminist standpoint theory is a useful tool to give voice to the women's experiences at a particular time and place within a patriarchal social setting (Haraway, 1988:590).

The HBC policy is convenient in compensating for the scarce provisions of the state. The role of the relatives has increased while the state provisions has become less generous and universal, impacting negatively on the women's ability to take part in paid work.

Behind every tragedy of death and illness from AIDS, there is a caregiver - usually a woman who has borne not only the impact of the loss of loved ones, but also the enormous cost of time and energy and resources to provide this care. Regardless of the culture, women are responsible for domestic work within the household and the provision of care to family and relatives, ranging

from bringing up children to caring for the sick and the elderly. Women pay an opportunity cost when undertaking unpaid care work for HIV/AIDS-related illnesses as their ability to participate in income generating, skills-building and leisure activities is drastically reduced. This is also costing on their being empowered which even affects the entire family. For the standpoint to be fruitful in providing complete and less distorted information, it needs to be sensitive to the differences as well as commonalities of women's labour across class, culture and race divisions (Harding, 1993). As it is in Botswana different classes may experience the caregiving differently as high class women have an alternative of hiring somebody else to do the caregiving, but this still boils down to the fact that the caregiver hired to do the work will still be a woman of low education and low class, striving to make ends meet to feed her family in turn.

The Feminist Standpoint theory according to Anderson (2009) has the primary function to empower the oppressed so that they are able to improve their situation. This is achieved by representation of the social world for the interest of the oppressed groups, supplying the information for the groups to enable them to understand their problems, and finally to supply the information for the subjects to use in improving their situation. In this way, the theory may offer true representations that are of more use to the women, hence claim to "privileged access to reality". Objectivity in Feminist Standpoint is about positioned rationality achieved by challenging the patriarchal system and giving sight and voice to the oppressed groups by seeking situated knowledges made possible by communities (Haraway, 1988:590). Anderson (2009) points out that Feminist Standpoint theory have the advantages in raising the central question about the justification that women have been and are oppressed. To me this is an important question and an eye-opener for the Botswana women that have been made to believe that their oppression by the male dominancy is a natural part of their daily lives. Another advantage is that of understanding that the knowledge is situated and perspective, and that this knowledge is produced from the oppressed group's standpoint.

5.3 The caregivers' experience of the Health services interventions

All of the interviewees reported on having established networks with the health services. Some of the caregivers are themselves infected with HIV and have to go for regular check-ups and fetch their antiviral medication. All the caregivers are even responsible for accompanying their sick

patient to the health care center for the check-ups, which means that they also have an established contact with the health care staff in the village. In contradiction with the information given by the chief of social work department about gaining access to people who are in need of social services through the police, the hospitals and the health clinic, this does not seem to be the case. These people are frequently at the village health clinic, but have had no contact with any social worker.

The burden of poverty becomes more intensive where treatment, medical care, or social and economic resources are unavailable. In this context where there is poor of access to water, the women have to spend many hours to fetching, due to the increased quantities of water needed for the care of the sick. In Botswana the policy is that the first time a person receives the results that they are HIV positive, they are to be offered counseling at once. This counseling however does not continue and does not extend to the rest of the family.

The hospital told us that we should use gloves, and how...and we ended up doing that...they gave them to us. In the clinic they do tell us...[sigh]...even the time when they were counseling us after it was discovered that we had the virus...he ended up sitting with us and telling us how we should learn to accept our status and that for us to stay fit we should avoid getting depressed over our status...to accept ourselves so that we can get proper treatment...so that the medicine can work properly because if you are depressed like that the "soldiers" [CD 4 count] also drop down. I ended up accepting my status and now I am on medication.

While this is an excellent intervention in the HIV/AIDS pandemic, it is not extended to the caregivers in their daily contact with the infected patients. The health care services do offer gloves and plastic sheets to be used for the sick person, but apparently this information does not reach all the caregivers. Some of the caregivers reported that they do not have the information about the process of the disease and lack the knowledge of how to handle and give care to the infected relative.

For the country to deal with negative consequences of the impact of the HIV/AIDS pandemic, the health department is not actively engaged in assisting the caregivers the process. With the introduction of the HBC policy has not been pronounced guidelines and working directives on what kind of assistance will be offered to the people giving the caring for the sick. The next-of-kin also give the impression that there are no evaluations on the implementation of the policy.

I agree with Lister (2004:100) emphasizing the need to understand poverty as a social relation where social processes such as stereotyping, stigmatization and categorization serve to portray the poor as homogenous group.

Poverty faced by the women is shaped by the interaction between gender, class and ethnicity and the unequal relations in the national economy (Heyzer, 1994). As a result of the gender hierarchies in Botswana, the women are experiencing an unequal access to food, education, mobility, health care resources and less power.

Some of the caregivers report that they have not received any kind of information regarding the process of the disease and no training on the handling of the patient has been given to the people responsible for giving the everyday care. In the worsening of the sickness, the caregivers, report that they did not get any assistance to transport the sick patient from the rural village to the hospital in town for emergency medical attention.

Oh [pause] as you can see I'm sick with high blood pressure [pause] and who knows, maybe I also caught the virus. [Pause], when I was taking care of my children, I didn't know anything about this disease [pause] nobody told me that I had to use gloves [pause] so I just used to touch them, wash them without gloves [pause] maybe even this is not high blood pressure [sigh], it's the virus attacking me this way, they say it can come in different ways. Nobody told med anything. These people they don't really care because they know [pause] they know that the mother will take care of her children (interviewee 6).

The only thing is for me to bring him here [pause] to the clinic. [Sigh] like there was one time that he was very sick and I had to transport him to the hospital in Molepolole [pause] it was difficult [pause] I had to pay for a car to drive him in the middle of the night (interviewee 1)

The poverty experienced by women is passed on to the children, especially the female child. A social protection benefit would reduce the need for the elderly women to seek income earning opportunities, and avoid the necessity for adolescent girls dropping out of school prematurely to seek work. Advocacy and education campaigns are necessary to raise the visibility of women's work within the household and how this work is affected by HIV/AIDS. Since the beginning of the HIV/AIDS pandemic, there has been a shift in the cultural kinship. The elderly have now been forced to step to take care of their adult children who have been infected with AIDS.

[Long sigh] my child, I had 6 big children, women and men [pause], but now there is only one left and she is sick. She has become a cripple who can't even use her legs. I have to push her in a wheelbarrow to bring her to the clinic. [Sigh] as I'm talking to you, she is lying under the tree there waiting to see the doctor (interviewee 3).

The elderly woman has no means of hiring a car to drive the sick patient nor does she receive any kind of assistance, such as an ambulance to drive the terminally sick patient to the health care center. Her only resort is to push her sick daughter in a wheelbarrow to get her to get the needed medical attention.

It is important that poverty alleviation strategies, governmental policies strengthen the women's claim to resources and access to information by including the women in the decision making processes and their experiences in implementation processes (Heyzer, 1994).

5.4 The role of the extended family in the support system for the caregiver in their immediate family

The extended family has taken over the role of building strong support systems in the care of people living with HIV/AIDS in Botswana. The extended family includes grandparents and neighbours. This support system has not just began with the HIV/AIDS epidemic, it has always been there, whereby grandchildren are left with the grandparents while the parents are away working in the city and the elderly always knew that when they become older and can no longer take care of themselves, one of the children will take care of them and give them financial support

It's very difficult with money...miss, we are only fortunate to have good neighbours that sometimes bring us food and sometimes when the patient is a little better I can leave him with our eldest daughter and do somebody's washing or help them weed in their yard. (Interviewee 2)

As the quotation reflects, it is difficult for the caregivers to find a day job where they can earn just enough to feed the family. Like some of the interviewees say, they have good neighbours and parents that come in and lend that helping hand when its most needed. Some of caregivers are old but have had to step in and give care to many of their children that have died with AIDS-related sicknesses. This is also against the kinship unwritten rule in Botswana whereby the elderly are taken care of by the younger. The oldest amongst the interviewees reported that;

...my child...it is so painful to bury one child after the other ...[tears] there is totally nobody at all to help me in this. Before the others...died...I got help from the healthier ones...but now [pause] now [pause] I'm left all alone. Look at me...I'm old and I can't even lift the patient when I have to give her a bath, the neighbours are kind, the lady comes over to help me with lifting, but everything I have to do myself (interviewee 3).

The above caregiver is a pensioner, but even that amounts to nothing, when she has to feed herself and the patient. The pension fund in Botswana gives all pensioners P236 every month. This amount is really meant to provide for the elderly persons. It is not enough for monthly groceries due to the rise in prices but the amount has been the same.

All the interviewees are women with very low education and as some of the quotations show; many of them have held low paid jobs such as working as maids or farm hands for neighbours. This brings us to the next theme. These roles have existed for a long time, and differ across cultures to a certain extent, but have some factors in common. In agreement with the social constructionist theories (Mead, 1935) I argue here that gender roles are socially constructed. Mead (1935) argues that gender is constructed within cultures in response to the local situations and histories. The social constructionist also acknowledges the differences of roles described for men and women and the variation of sex roles as context related. In this case the context of a rural area in a developing country in Africa South of Sahara. Furthermore the social constructionist point to the environmental factors such as culture and developmental experiences as shaping the social roles that we take on. I argue that social roles are embedded in the social cultural context and by placing men and women in different categories the social structure cultivates a process of sex-different behavior (Wood and Eagly, 2002).

The deep-rooted kinship system in Botswana that has acted as a social security for the children, the elderly and the sick has been exploited to the maximum by the state. Not only do the older women, “granted mothers” often find themselves the sole career and providers of orphan children but even their sick parents.

Loss of household income due to sickness and death can also force the older women back into the productive sector. Women’s role in the care economy intensifies women’s poverty and insecurity as opportunities for income generation are lost and a large portion of an already meager income is spend on care such as water, gloves, funeral or medical needs.

Women still remain the bearers of this support system and have to pay the price of caring (Lister, 2004: 57).

There is a growing need to draw focus to and find solutions to sustain the value of women and the family life in Botswana (Women's Affairs Department, 2003). The poor families are marginalized and treated as different from the rest of the society in the discursive construction of "the poor" as "others" (Lister, 2004: 100).

5.5 Personal experiences of the caregivers in their care work

All the interviewees as already mentioned are women of different ages living in a rural village in Botswana, all giving care to very sick relatives with AIDS. They all agree that caring for such a sick person is a very difficult job. On the other hand they all explain that it is their duty to give care to the sick relatives as nobody else can do it. They all smiled at me when I asked whether they have ever thought of handing over the caring job to somebody else.

Yes [pause] yes [pause] it was very difficult taking care of a person who was once a strong man but had become as helpless as a baby...you know...people with this disease...it's like they go back to become like babies (interviewee 1).

[laugh]...leave him! That's impossible [pause]...who would take care of him? His mother is too old to take care of him, and his sisters are also taking care of sick relatives [pause] ...and really, it is was my duty to take care of him, we take care of our relatives when they are sick...it is our culture! (Interviewee 1)

The caregiving work takes up the women's time, as they have to stay close to the sick person, to feed them, bathe them and wash their clothes. At a certain stage the sick person cannot even stand up to get water for themselves so the constant need of a helper retains the women in the home and they cannot leave the home. Despite the difficulty of giving care to their loved ones, all the caregivers look at caregiving as a role that only a woman can do.

Policies such as the home-based care policy in Botswana pay little attention to gender equality and the normative constructions of gender intersect in the lives of next-of-kin caregivers (Sandberg et. al, 2009) The women carry an expectation that they are responsible for giving care, even playing a leading role in family care that in turn raises feelings of role captivity in their own lives (ibid). Due to the socialization of roles from childhood, many of the next-of-kin caregivers

take on the role of caregiving without fully realising the meaning of it. Socialization of roles is also to do with the way people interact with others and how their expectations and reactions cause others to respond in a certain way. These expectations and behaviours that are associated with particular positions and that affect the way people react to changes in life (1985).

The other caregivers says

my mother-in-law. [pause] she was sick, very sick miss [pause] and her husband couldn't manage to take care of her [pause] you know [pause] to wash her and to wash for her [pause] this things. So...I told my boyfriend...we can take care of her [pause] at least if there's a woman there to wash her ...you know. I went to their home every morning to help her...and came home in the evening. [Ah] in the end she died...to leave her there...just leave her there with him. My boyfriend is very supportive...Even the time that they caught the virus on me, he has been there, going to the doctor with me [pause] none of my relatives supported me...even sometimes here when the men they find out the woman has the virus and he doesn't have [pause] they leave her...saying that the woman was cheating...but he...he was with me all the time and he's the one who reminds me to take the tablets if I forget. ...We have been together 9 years and all this time he has never hit me. Yes...even like I have been living with HIV, this man that I live with he doesn't have it...not even my child...he doesn't have it...I'm the only one with it here in this yard (interviewee 7).

A woman's work...really it's not a thing that you choose or like that...it's that thing that our mothers taught us...that is like that...the man he can't manage to give the patient a bath or to wash the soiled clothes and blankets...he can't (interviewee 8).

When I started out with this research, one of my hypotheses was that, the caregivers have become too tired and bitter about being forced to take care of their sick relatives. This proved to be false. I met happy but tired women that even though I could judge from their clothing that they were poor, the clothes were clean, and they smiled now and then between the sighs and pauses.

The unpaid care work is gendered in consistence with women's traditional roles of caregiving. The women all say that giving care is "their role" and that no man is capable of carrying it out. This kind of reasoning theorists such as Walby (1990) and Mead (1935) write about. As they point out these roles are shaped by the context and environmental factors such as culture and developmental experiences (Wood & Mead, 2002). These social roles are embedded in social

cultural context and are therefore difficult to change. In Botswana and the rest of the world women have been thought by their parents right from childhood that they are responsible for caring for everybody in the family. The women not only see themselves as the only people who are capable of giving care but even see this as expected of them (Croffman, 1968b).

Women in Botswana have been taught to not to complain about their problems publicly, which means that even if the caregivers see their roles as problematic they will keep it to themselves and the immediate family. It therefore important for the policies passed to take consideration to the women's social roles puts them at a disadvantage and the stereotyped images of activities that contribute to expectations of gender roles (Belloti, 1975; Comer, 1974; Sharpe, 1976).

The women in cultural Botswana are acting on expectation due to the cultural expectations and the normative pressures (Leacock, 1978; Prato, 1996). These roles have existed for a long time, and differ across cultures to a certain extent, but have some factors in common. In agreement with the social constructionist theories (Mead, 1935) I argue here that gender roles are socially constructed. Mead (1935) argues that gender is constructed within cultures in response to the local situations and histories. The social constructionist also acknowledges the differences of roles described for men and women and the variation of sex roles as context related. In this case the context of a rural area in a developing country in Africa South of Sahara. Furthermore the social constructionist point to the environmental factors such as culture and developmental experiences as shaping the social roles that we take on. I argue that social roles are embedded in the social cultural context and by placing men and women in different categories the social structure cultivates a process of sex-different behavior (Wood and Eagly, 2002).

One of the caregivers, almost totally blind, but still has to take care of her sick son, but she also gets help from the farm hands that has been living and helping the family with other odd jobs since a long time back. The farm hand does not get any payment for helping the blind woman with her patient. She gets other kind of payment for her farm work in either, maize, beans or sorghum to feed her own family in turn.

my child, I had to take one of the people that normally help us in the farm to be my eyes. [Sigh] she helps me to lift the patient, to bath him and wash for him and fetch water, and I feed him and sit with him. [Sigh] his sisters can't help me; they have their own homes to take care of (interviewee 5)

The impression is that all the women see their care work as a given thing. They all speak of caregiving as if it's their call in life and that in their culture it is unheard of to hand over your caregiving responsibility to any other person, it's unthinkable.

5.6 The family's economy

Some of the younger women who have worked as maids or farmhands have had to leave their jobs to take care of the sick person, and this has affected the financial status of the family at large as the women have been the main breadwinner. They all report living under very strained financial constraints.

One of the interviewee reports that

Money...[sigh]...really we just...even my boyfriend doesn't work. He is a person who sometimes takes piece jobs helping people to fix their cars. When there's no money...otherwise there's only farming...really farming is what we do (interviewee 1).

It's very difficult with money...miss, we are only fortunate to have good neighbours that sometimes bring us food and sometimes when the patient is a little better I can leave him with our eldest daughter and do somebody's washing or help them weed in their yard (interviewee 2).

...money [pause] money is a problem miss...my mother helps us sometimes when she gets her food basket from the social workers, and like [pause] like last week, then his sister came to stay with him because they called me to help them to weed their yard [pause] the people that I help with household chores, I mean (interviewee 4).

Some of the interviewees have fields and cattle which in Botswana is considered rich. If one is able to plough their fields and have cattle, then there is a possibility to sell the products from the fields and or sell a cow in case money is needed. Otherwise there is always food from the fields to feed the family.

Some of the interviewees who's patient has already died have tried to look for jobs to try and improve their financial situation but as the quotation below shows, there is still a great deal of stigma amongst family members, relatives and in the community at large that acts as a great obstacle for people living with HIV/AIDS. Some couples even end up breaking up due to the stigma.

Social psychologists argue that the effects of relationships within and between groups of people such as how people behave in relationships and to them are the subject of social psychology. This also refers to the way people influence each other and how they react to the effects of social factors such as stereotyping, ideology and stigma (Hogg and Abrams, 2001). Communication is an important tool in social interactions both at the individual and group level as power relations arise from the use of language to give meaning certain views of the world (DeVito, 2002). The social role theory gives emphasis to how we form and manage relationships in our social situations and the issues of identity in relations to matters such as stigma, group behavior, the effects of environments, territory and material on social and personal change (Breakwell and Rowett, 1982).

...really it's a problem with money. [pause] like I have tried to get a job as a maid [pause] but the people [sigh] the people treat you like a dog when they know that you're infected [pause] they don't want you to cook their food or like that [pause]. And they don't want to understand that you have to go for your scheduled time with doctor [pause] I mean, they just think you are going to do your things [pause] they don't think it's important. At the clinic [pause] they tell us it is very important to take medicine properly and on time. [pause] but these people [...] so me, I can't work as maid anymore because of the way they treat us (interviewee 7).

In the quotation below, the patient has died and the woman is working as a generator operator for the village well. This job is a one person job, and she cycles to the well every morning to check the generator and then goes on home to fry "fat cakes" to sell at the village health center. This is like a small tuck shop being operated from a table by the entrance of the center.

Stigmatization is one of the biggest problems in the HIV/AIDS pandemic. Exacerbating strains on the household, customary laws and gender inequalities often leave the women without any chances of inheriting property or land, or left as destitute and stigmatized by the community. The women are often deprived of the rights to paid work due to the stigma. In the rural areas there has been a collapse in coping systems that have helped women to feed their families for centuries during times of drought and famine. This has led to family breakups, migration and greater risks of HIV infections. The cycle continues as girls often drop out of school to help in the care work, falling deeper into poverty and their children so.

The structured-functional role theory explains these positions as the way people interact with each other and how expectations and reactions cause certain responses (Howard & Johnsson, 1985), leading to masculine and feminine identities that result in women in the subordinate roles, with less status, power and resources.

Even now...I'm the only one working, the husband is not working, even the children are not working...as you saw her there...she's not working...she has a new baby. If the woman doesn't make sure that there's food at home then...whole family is suffering...if I'm not working there's nothing...I'm the only one feeding the family...that's the way it is (interviewee 8).

When I was preparing for the long drive to meet the interviewees, I thought I was going to meet a group of sad people who have lost all hope in getting a better life, but this was not the case. I was met by a group of fighters, hopeful women who are ready to find ways to keep moving and better their economy, a group of women who want to give their children better education and eventually a better life. Some of the comments that I received are as follows;

I wish...you see chickens, if it wasn't for the problem of many chicken diseases, I wish I could...because many times growing vegetables...growing vegetables is a lot of work, and being a woman who has children, like I have children, you end sometimes [...sigh...] like water here is a big problem, the vegetables are going to end up dying [laugh]...and as careless as I am! I don't even have a tap in my yard, and I have to queue for water (interviewee 1).

...I really want to continue with my tuck shop...but as I told you before...I can't because...of the money...But also...this association that we want to form...we need some donations to start working...because I believe in this...it's good (interviewee 7).

It is important to understand whether masculine and feminine identities are a result of a process of socialisation (Belotti, 1975; Comer 1974; Sharpe, 1976) as socialisation is considered to take place primarily during childhood, where boys and girls learn the appropriate behavior for their sex. Starting from the baby stage where little girls are given dolls in preparation for care later on groomed to help their mothers with domestic work while boys are out playing with their friends. These are examples of the stereotyped images of activities that contribute to expectations of the present and future gender roles which are also apparent in the media and add to the subordinate concept of the women. In the division of labour women perform more domestic work than men and those who do enter the labour market spend fewer hours in paid employment and have lower

wages than men. In many societies and in Botswana women have less status, power and resource, leading to gender hierarchy in the social structure (Roodie, 1989). Gender roles are formed when each sex is expected to characteristics that equip it for its sex-typical roles, therefore gender roles are shared expectations that apply to individuals on the basis of their socially identified sex (Eagly, Wood & Diekmann,). These expectations act as normative pressures that foster behaviours consistent with sex-typical work roles. Although sex-different roles differs in cultures, a common factor across cultures is that status and power differences that are typically in favour of men do exist within societies and vary across societies (Leacock, 1978; Prato, 1996). Women are brought up to mother early in their childhood and although this is a rich experience, it also traps the women into unrewarded roles than men in contemporary society (Walby, 1990).

In Botswana, the traditional society expectations also play an important role on the family way of life. Women are taught from an early stage that care giving is their role in society and failure to fulfill that role is a disgrace both to the family and the society at large. Chicken rearing has become a big business in Botswana, mostly among women of low education who cannot get a better job than working as a maid or farm hand.

6 Discussion

In this chapter I shall carry out a discussion on the study's findings and even the questions that were raised during the course of the research. In this section I shall even elaborate more on the findings with the ambition to answer the study's research questions. Botswana is one of the countries with the highest percentage of people living with HIV/AIDS. Although the country has established health care services, these were experiencing financial stress due to the amount of infected people that needed health care, hence the formulation of the home-based care policy. In Botswana and in many countries women have been responsible of giving care to children, the elderly and the sick, but the HIV/AIDS pandemic brought with it even bigger challenges for the women. With the home-based policy, the very sick people who are in their dying bed are to be taken care of in the home by the woman in the family, meaning a transfer of the health care's responsibilities over to the next-of-kin.

To answer my first research question: *Is there any governmental assistance offered to caregivers and their families?*

Being rated one of the fastest economic countries in Africa and a picture of democracy, Botswana has 47% of the population living in poverty and a high rate of women-headed households. These constitute the majority of the poor households in Botswana. With the introduction of the home-based policy in Botswana due to the financial pressure that was being experienced by the health department, hospitals and health clinics due to the high percentage of people living with HIV/AIDS this meant an increased workload for the women who would step in to give care to the sick people. Despite the transfer of care responsibilities from the health care system, over to the next-of-kin, the government has failed to build pronounced support systems for the caregivers in the sense of financial, psychological and practical resources that will sustain them in their work. The patients are handed over to the next-of-kin without even an assessment of the homes or the capacity of the whole family setting, like in the case of the old woman who has been forced to take care of her sick children could be avoided. The caregivers are not properly informed and trained in the handling of the patient to reduce the risk of infections. Furthermore the financial status of the family should be assessed with the aim of giving financial assistance. There are no financial resources what-so-ever targeted at the next-of-kin caregivers by the social services or any other governmental department.

Lastly, while it is important to address ways of dealing with provisions of access to drugs, investments in prevention and access to information on HIV/AIDS, there is a greater need to provide support mechanisms for women's work in relation to HIV/AIDS. It is also critical to address the vulnerability of poor households and communities. Little has been done to decrease or alleviate the social and economic impacts of the HIV/AIDS pandemic on the lives of people in affected households. There is critical shortage of home-care kits containing gloves, soap, disinfectants and other basic necessities. There is little or no support from the governments

While counseling is given to people who discover that they are HIV positive, the concern is that there is no psychological assistance for next-of-kin caregivers in their everyday work. Even though caregiving should be incorporated in the health, mental and social services, the next-of-kin caregivers are actually completely neglected by the government in every perspective.

Women have been the sole providers of care for many centuries in Botswana and in many countries, such as Sweden. Unlike Botswana, however, countries like Sweden have long introduced policies and laws to protect and support caregivers (Anhörig, 300). Even though women are still the main bearers of caregiving for their next-of-kin, the state has taken heed of available research and financial resources have been put into creating support systems for caregivers. Apart from this support system the caregivers have social security support to ensure that they have both financial and psychological support.

In the attempt to answer the next research question; *What is the experience of women in their roles as caregivers?* I found that all the next-of-kin caregivers see their role as a given one. They all proclaimed the difficulty of caring for a sick person with the almost no means of financial support or guidance from the government. Despite the difficulty of giving care to their loved ones, they all carry an expectation of themselves as their womanhood being responsible for giving care, while at the same time they gave the impression that they did not really think that things would turn out the way that they had. None of them gave me the impression that they expected any kind of help from the government as caring is what they are "born" to do and cannot be transferred to any other person. The caregivers kept repeating that it is in their culture to give care to their sick relatives and found it surprising that I could think otherwise.

On the other hand, the caregivers talked about the sad moments in their caring role where they have to ask for handouts from the neighbours to be able to feed the family. Some of them also talked about the difficulties in transporting their patients to the hospital for emergency medical care, saying even that they did not get any kind of help from the hospital or the council to transport the sick patient so much that they have to find money to hire a vehicle. They further talk about the shortage of the money as they are not able to take the odd jobs that they used to do before as house-maids or farm-hands due to their role of caregiving.

While talking to the women caregivers I found out that even though they were poor and have had to deal with devastating experiences in their lives, they have not given up in trying improving their lives for the better. They talked about wishes of being able to start small poultry farms or small tuck-shops to generate income but they all lack the start capital. If there were structured evaluation systems of policies, the state would find out the negative impact on the caregivers in time.

This is where I think NACA Botswana could go in and help the caregivers with the capital to start their businesses.

The problem of stigmatization is a well-known phenomenon in the HIV/AIDS pandemic, but this is still being practiced by people and even though there are campaigns against it, there are still no specific ways of discovering the discrimination against people with HIV/AIDS. Thus stigmatization remains a challenge to people living with HIV/AIDS and results in traumatic experiences and contribute to their not being able to stay employed or enter the employment market.

Home-based care as currently practiced in Botswana amounts to the transfer of the responsibility of care to women who are already burdened by poverty and deprivation; thus, it serves to aggravate the existing burdens on women who are, and will continue to be, the main caregivers of the sick for a long time to come.

Finally, a discussion that will lead to answer the question; *What are the standpoints taken by the women in regard to care giving and poverty?* All the next-of-kin caregivers that I interviewed were eager to tell their stories to me. The plans of starting up an association seemed to be a driving force for the women to get out and do something that could bring in some kind of financial independence, a way to meet other people in the same situation that they can talk to and find some relieve in their daily work. The younger caregivers all talked of wishes of starting up small businesses to support themselves and their families.

Their way of reasoning is that they do not mind giving care to their sick relatives as it is their duty, and actually they do not blame their caregiving role as a contributing factor to their poverty. The only thing is that, since they cannot leave the sick person alone, they are unable to get out and earn money therefore they have become poorer. In some way these women have accepted their way of life, and their "status" without questioning the practices in the society.

My impression of the interviewed caregivers is that they are determined to continue to strive for a better life for themselves and their families, making sure that their children get better education possibilities than they ever got.

7 Concluding Remarks

In conclusion, I have found out that the in the introduction of the home-based care policy in Botswana, the women's position has been taken for granted by the government. While planning the policy, little attention is given to the gender perspective and there are no pronounced support systems from the society to assist in the work load or financial constraints experienced by the families. There is no proper assessment and training targeted at the homes expected to give care to an AIDS patient.

With regard to the social welfare services in Botswana, I have learnt that there is much to be improved. There are no proper systems for accessing information on the people in need of social welfare services, not enough economic resources to buy vehicles to transport the few social workers to the remote areas in the district and no financial or psychological resources targeted at the next-of-kin caregivers and their sick patient.

The women talk about caregiving as an expectation not only as their own, but as of the rest of the society and see it as a cultural call that no man can do and that cannot be passed over to anybody else. I realised that not only does the government take the women's position for granted in policies such as the home-based care policy, but the women themselves take their positions for granted. All of the interviewed women are uneducated and live in great poverty that has worsened due to their role in unpaid work.

However I commend the interviewed women in their hopes of empowerment, their strive to start up an association to take care of the village orphans, that will probably even give them some kind of autonomy, a sense of taking part in the village development. Their fiery spirit of keeping on moving and wishes of starting up small businesses is commendable.

I recommend that more research should be conducted with the aim of suggesting better ways of installing and implementing support systems for next-of-kin caregiver in Botswana. Such support models of next-of-kin caregivers as those in Sweden and other Scandinavian countries but at a smaller scale could be a guiding tool for a developing country as Botswana.

References

Books and articles

- Agarwal, B. (1994). *A field Of One's Own Gender and Land Rights in South Asia*. USA:Cambridge University Press.
- Akintol, A. (2004b) Home-based care: A gendered analysis of informal caregiving for people living with HIV/AIDS in a semi-rural South African setting: *Unpublished Ph.D Thesis*. University of KwaZulu Natal.
- Akintola, A. (2008). Defying all odds: Coping with the challenges of volunteer caregiving for patients with AIDS in South Africa. *Journal of Advanced Nursing*. 63 (4): 357 - 365.
- Akintola, A. (2010) Perceptions of rewards among volunteer caregivers of people living with AIDS working in faith-based organizations in South Africa. A qualitative study. *Journal of International AIDS Society*. <http://www.biomedcentral.com/content/pdf/1758-2652-13-22.pdf>
- Akintola (2006). Gendered home-based care in South Africa: trouble for the troubled. *African Journal of AIDS Research*. 5(3): 237–247.
- Akintola, A. (2010). *Unpaid HIV/AIDS Care, Gender and Poverty*. in Antonopoulos, R. & Hirway, I. *Unpaid Work and the Economy: Gender, Time use and Poverty in Developing Countries*. New York: Palgrave Macmillan.
- Alvesson, M. & Sköldberg, K. (2008). *Tolkning och reflektion –vetenskapsfilosofi och kvalitativ metod, 2:a uppl*, Studentlitteratur
- Anderson (2009). Feminist Epistemology and Philosophy of Science In *Stanford Encyclopedia of Philosophy*. *Stanford University* <http://plato.stanford.edu/entries/feminism-epistemology/#standpoint>
- Antonopoulos, R. & Hirway, I. (2009). *Unpaid Work and the Economy: Gender, Time use and Poverty in Developing Countries*. UK: Palgrave Macmillan.
- Antonopoulos, R. & Hirway, I. (2010). *Unpaid Work and the Economy: Gender, Time use and Poverty in Developing Countries*. New York: Palgrave Macmillan.

- Antonopoulos, R. & Toay, N. T. (2009). From Unpaid to Paid Care Work—The Macroeconomic Implications of HIV and AIDS on Women's Time-tax Burdens. *The Levy Economics Institute Working Paper No. 570*
http://www.levyinstitute.org/pubs/wp_570.pdf. Accessed on November 11, 2011.
- Belotti, E. G. (1975). *Little Girls: Social Conditioning and Its Effects on the Stereotyped Role of Women During Infancy*. London: Writers and Readers Publishing Cooperative.
- Blaikie, N (2007). *Approaches to social enquiry: advancing knowledge*. Polity Press: Cambridge.
- Breakwell, G. M. & Rowett, C. (1982). *Social work: The social psychological approach*. Workingham: Van Nostrand Reinhold.
- Bryman, A. (2008) *Social Research Methods*. Oxford University Press Inc. New York.
- Campbell, C. and Foulis, C. (2004). Creating contexts for effective home-based care for people living with HIV/AIDS. *Curationis*. 27 (3):5 - 14.
- Cargan, L. (2007) *Doing Social Research*. Lanham, Md.: Rowman & Littlefield Publishers.
- Descombe, M. (2000). *Forskningsboken*. Lund: Studentlitteratur.
- Eagly, M. R. & R. H. Hoyle (2009). *Handbook of individual differences in social behaviour*. The Guilford Press: New York.
- Ely, M. (1993). *Kvalitativ forskningsmetodik i praktiken. Cirklar inom cirklar*. Lund: Studentlitteratur.
- Eswaran, M. & Kotwal A. (1994). *Why Poverty Persist in India: A Framework For Understanding the India Economy*. UK: Oxford University Press.
- Flick, U. (2006). *An Introduction to Qualitative Research*. London: SAGE Publications.
- Gilje, N. & Grimen, H. (2003). *Samhällsvetenskapernas förutsättningar*. Göteborg: Diadalos.
- Goffman, E. (1968b; 1922 - 1982). *Asylums: Essays on the social situation of mental patients and other inmates*. Harmondsworth: Penguin.
- Haraway (1988) Harding, S. 1991. *Whose Science? Whose Knowledge? Thinking from Women's Lives*. Open University Press: Milton Keynes.

- Harding, S. 2004. Introduction: Standpoint Theory as a Site of Political, Philosophic, and Scientific Debate In *The Feminist Standpoint Theory Reader: Intellectual & Political Controversies*, 2004, New York and London: Routledge, 1-15.
- Harding, S. (1991). *Whose Science? Whose Knowledge? Thinking from Women's Lives*. Open University Press: Milton Keynes.
- Heyzer, N. (1994). *Gender, economic growth and poverty: market growth and state planning in Asia and the Pacific*. New Dehli: Kali for Women and international Books, Netherlands in collaboration with Asia and Pacific Development Center. Kuala Lumpur.
- Ho, C. and Schraner, I. (2004). *Feminists Standpoints, Knowledge and Truth*. Working Paper No.02. *School of Economics and Finance*. University of Western Sydney. June
- Hogg and Abrams (2001). *Group Processes*. Malden, Mass. Oxford: Blackwell.
- Kabeer, N. (2003) *New Gender Mainstreaming series on Development issues: Gender mainstreaming in Poverty Eradication and the Millennium Development Goals: A handbook for Policy –makers and other stakeholders*. Commonwealth Secretariat. Canadian International Development Agency. Canada.
- Kvale, S. (1997). *Den kvalitative forskningsintervjuen*. Denmark: Narayana Press.
- Kvale, S. (2006). Dominance through interviews and dialogues. *Qualitative Inquiry*. 12(3): 480-500.
- Lindsey, E., Hirschfeld, M., Tlou, S., & Ncube, E. (2003). Home-based care in Botswana: Experiences of older women and young girls. *Health Care for Women International*. 24:486–501.
- Lister, R. (2004). *Poverty*. UK: Polity Press.
- Marlow, C.R. (2005). *Research Methods for Generalist Social Work*. USA: Thomson Learning 10 Davis Drive.
- May, T. (2001). *Samhällsvetenskaplig forskning*. Lund: Studentlitteratur.
- Mead, H. (1967). *Mind, self and society: from the standpoint of a social behaviourist*. The University of Chicago press: Chicago.

- Orner, P. (2006) Psychosocial impacts on caregivers of people living with AIDS. *AIDS Care*. 18 (3): 236 - 240.
- Reinharz, S. (1992). *Feminist Methods in Social Research*. New York: Oxford University Press.
- Ruane, M.J. (2006). *A och O i Samhällsvetenskaplig forskning*. Lund: Studentlitteratur AB.
- Sandberg, J. et al. (2009). Keeping the family balance - adult daughters' experiences of roles and strategies when supporting caring fathers. *European Journal of Social Work*. 12 (2): 233 -245.
- Sen, A. (1992). *Poverty and Famines: An Essay on Entitlement and Deprivation*. Clarendon Press: Oxford.
- Sharpe, S. (1976). *Just Like A Girl, How girls learn to be women*. London: Penguin.
- Walby, S. (1990). *Theorizing Patriarchy*. Oxford: Blackwell.
- Ridgeway C. (2002) *Framed by Gender*. London: Oxford University Press

Report

- Anhörig 300: Slut rapport (2002). accessed from http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/11150/2002-124-15_200212415.pdf
- Help Age International (2004). accessed from <http://www.helpage.org/hiv-and-aids/>
- Socialtjänstlagen (2001:453) prop.2008/09:82, SFS 2009:549. Accessed from <http://www.regeringen.se/content/1/c6/12/83/07/c4225358.pdf>
- Medium Term Plan [MTP] (1997 – 2002).accessed from <http://www.unaidsrstesa.org/regional-country-profiles-home/country-profiles/botswana>
- Ministry of Labour and Home Affairs. November (2000)
- NACA Botswana (2008) accessed from <http://www.naca.gov.bw/>
- National Gender Framework, Botswana. (2004)

- Physicians for human rights. (2007) accessed from <http://physiciansforhumanrights.org/library/reports/botswana-swaziland-epidemic-of-inequality.html>
- UNAIDS. (2009).accessed from http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/report/2009/jc1700_epi_update_2009_en.pdf
- Women's Affairs Department, Report. (2003)
- World Development Report. (2000/2001) accessed from <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,contentMDK:20195989~pagePK:148956~piPK:216618~theSitePK:336992~isCURL:Y~isCURL:Y,00.html>
- World Bank website. accessed from <http://data.worldbank.org/country/botswana>
- UNDP. (2008). Global Progress on the Millennium Development goals. Accessed from http://www.undp.org/mdg/basics_ontrack.shtml