

HIV/AIDS, Intra-family Resource Capacity and Home Care in Maun, Botswana

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Abstract

Home care involves the transfer of a patient's medical supervision from a formal institution to a family setting in the context of a community. The aim of this paper is to assess the resource capacity of families to provide immediate home care to HIV/AIDS related chronically or terminally ill member/s in Maun in Ngamiland District. Data for the study was obtained through cross-sectional interviews with 61 care-givers. Ethnographic methods were also used: these included informal interviews with key informants, unobtrusive participant observation, and narratives of individual and family life experiences. Data collection focused on assessing family resource capacity to access three forms of capital, namely social, productive and produced. Issue focus analysis on qualitative data, and descriptive frequencies and cross-tabulations on quantitative data were carried out.

Generally, care-givers reported receiving non-material support from multiple sources. These included moral support from close family members, especially their own children, siblings, parents and spouses, and less from parents' in-law and their extended family. The threshold of care-giving resource demands could either fragment the family unit, on precipitate 'enclave-like' or 'disengaged' co-existence or passive aggression. On the other hand, care-giving resource demands may enhance mutual obligation and shared responsibility among family members. A high level of tolerability tends to reduce vulnerability and facilitate pooling limited resources in ways that enhance family capacity. Conversely, adversarial intra-family relations compromise the ability of a family to mobilize its resources. About 70% of care-givers were dependent on non-farming activities as their source of livelihood. Care-giving depletes family resources, including the abandonment of income generating activities. About 81% of care-givers said that they could not do anything to recover or reverse the loss. Access to produced capital such as telecommunication infrastructure is important in terms of the dissemination of public education information aimed at helping reduce risks and the prevention of infection. A significant proportion of care-givers had access to a radio (60%) and cell-phone (48%). The paper ends with some policy recommendations.

Background: HIV/AIDS Context in Botswana

A compendium of HIV/AIDS literature attests to the multidimensional global and regional impacts of the HIV/AIDS pandemic. In sub-Saharan Africa, these include escalating adult morbidity and mortality (UNAIDS, 2004; UNAIDS, UNFPA, UNIFEM, 2004; Commission on HIV/AIDS and Governance in Africa, 2004); increased vulnerability to poverty, emergence of vulnerable groups, precipitation of land and food crises (Barnett and Blackie, 1992; Barnett and Whitehead, 2002; Loevinsohn and Gillespie, 2003; Waal and Whiteside, 2003; White and Robinson, 2002); adverse impacts on family well-being (Booyesen, 2002; Desmond, Michael

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and Dow undated; Drimie, 2002; Ferreira, 2004; Mutangadura, 2000; Steinberg *et al*, 2002); and high level risk factors related to gender, culture and occupation (Ackeroyd, 2004; Schoepf, 2004; Susser and Stein, 2004; Zierler and Krieger, 1997).

Batswana continue to endure the shock waves of the HIV/AIDS pandemic since its outbreak more than two decades ago. The health care system in Botswana, as in other parts of Africa, had not been designed to cope with a high volume of HIV/AIDS related terminally ill persons. In 1994, the Ministry of Health institutionalised³ the Community Home Based Care (CHBC) programme as one way of alleviating the pressure of increasing numbers of HIV/AIDS related hospitalised patients. The envisaged goals of the CHBC programme are to provide appropriate care to patients and their families in a home setting, and to help families maintain independence and achieve the best possible quality of life (World Health Organization (WHO), 2002). The Ministry of Health (MoH, 1996a and 1996b) defines a CHBC patient as a person who has been medically diagnosed as terminally or chronically ill, including HIV/AIDS related diseases, and is registered as a CHBC patient by nurses and social workers implementing the programme. Home care involves the transfer of a patient's medical supervision from a formal institution – be it a hospital, clinic, or mental health facility – to the patient's family in a given community setting (Jacques and Stegling, 2001; Khan and Stegling, 2000). The CHBC programme in Botswana is not only meant for people living with HIV/AIDS, but also includes other chronically ill persons (such as those suffering from cancer, diabetes, hypertension, hemiplegia and paraplegia).

Since its inception, the CHBC programme has been an integral part of the National Primary Health Care (PHC) delivery system and also a central strategy for combating the HIV/AIDS epidemic in the country. According to a Ministry of Local Government (MLG) Report (2004), there are 14,656 registered CHBC patients nationwide, about 680 of whom are in Ngami sub-district (North West District Council Report, 2004). The programme implementation is a joint responsibility of the MoH and MLG. The MoH provides policy direction, coordination, training and other logistical support, while the MLG is responsible for human and financial resource allocation at the national and district level. In addition, various non-governmental organizations (NGOs) and Community Based Organizations (CBOs) also dispense CHBC-related services.

This is an exploratory paper whose aim is two-fold. The first is to assess the resource capacity of families who provide immediate home care to HIV/AIDS-related chronically or terminally ill member/s in Maun, an urban village in Ngamiland District of Botswana. The second aim is to investigate the extent to which care-givers and their families are able to recover from home care resource impacts. Our preposition is that HIV/AIDS-related care-giving constitutes a threat to actual and potential livelihood activities and opportunities.

Conceptual and Theoretical Framework

Family Strengths, Assets, Vulnerability and Resilience

We apply the Aspen Institute (1996) concept of 'capacity' as the commitment of knowledge, skills and resources (internally and externally produced by individuals, groups and communities) to address short-term problems and take advantage of opportunities in order to build

3. Following Luckham, Goetz, and Kalder (2003), and Giddens (1979), we regard an institution as a set of arrangements for organising the competition for resources and legitimating rules to ensure accountability. As such, CHBC services are structured by rules and norms that have been applied in contemporary Botswana.

strengths and create plausible solutions. When family groups commit resources to provide care and support, the ultimate goal is to reduce the underlying care-giving vulnerabilities. Commitment refers to a family group's willingness to act (based on shared awareness) on opportunities to find viable solutions to problems. Heightened responsiveness of the family interfaces with the receptivity of institutions outside family boundaries which mediate access to resources. The reaction of both institutions, therefore, could either weaken or strengthen intra-family resource capacity, and logically, the HIV/AIDS-related care-giver's ability to address care-giving problems. Skills, talents and knowledge of family members could be redeployed creatively to address emerging general and specific problems, and important opportunities to harness and galvanize pre-existing family strengths and minimize vulnerability.

Borrowing from Sen (1999) a family could also be said to be 'capable' in its 'functioning' from the point of view of its members' achievements. The quality of family life and its capabilities can be assessed not only in terms of individual members' achievements, but also the options or opportunities each member is able to choose from. According to Sen (1999) a person's functioning depends on personal (physical ability) and social factors (position in society and interactions with others within networks). Personal and social factors, therefore, contribute to family capabilities. We assume that the commitment of resources in care-giving is likely to have both positive and negative outcomes, and that the complexity of these results require systematic investigation.

In this paper, we conceptualize family strength (the outcome which individuals and groups may desire to achieve) in two ways. Narrowly, family strength refers to the extent to which social relationships and processes within the family maintain and enhance both individual and collective well-being. Looked at broadly, family strength refers to all resources and processes within a family and community that could be utilized to enhance self-reliance and individual and collective well-being (adapted from Black *et al.*, 2000). Therefore, if family strength is about access to and utilization of resources within family and community processes in ways that enhance rather than erode individual and collective well-being, then a caring family would be said to be 'strong' with a 'high' level of functioning. Caring *per se* is more than the voluntary provisioning of instrumental needs. When care-giving costs are shared relatively fairly and caring enhances overall interdependence and collective well-being, a family is most likely not only to develop the capacity to withstand shocks⁴ and stresses,⁵ but also to develop positively enduring social relations.

In a similar vein, care-giving within a family can occur at the expense of overall individual and collective well-being. Caring *per se* is more about the non-voluntary provisioning of instrumental needs, and care-giving costs are not shared fairly. Caring, in a weak sense, compromises overall family interdependence and collective well-being. Failure to collaborate further weakens family relations and thereby compromises interdependence, sustainability and the self-reliance of members. The costs incurred may be irrecoverable and unfair to other family members. We can describe family relations as 'weak' with a 'low' level of functionality. In this scenario, family members are unable to address a range of needs individually or collectively. A 'weak' and fragmented care-giving family is less likely to withstand shocks and stresses, and is likely to adapt negatively, both relationally and structurally.

The paper does not make assumptions about 'harmonious' or unbridled solidarity within

4. A shock can be regarded as a larger infrequent, unpredictable disturbance with an immediate impact (Baylies, 2002; Drimie, 2002; Ellis, 2000; Loevinsohn and Gillespie, 2003; White and Robinson, 2000; and Scoones, 1998).

5. A stress is a frequent, and sometimes continuous, relatively small disturbance which has cumulative effects (Ellis, 2000).

family relations, but it recognizes the existence of tensions and negotiations, conflict and collaborations, which depend upon access to resources and power. Social and institutional relations in a family setting are also played out along gender and age dimensions, among other variables. These relations, in the context of this paper, therefore, will be conceptualized as 'cooperative conflict' in terms of negotiating for power and resources (Sen, 1990). Although the willingness to provide care may depend on kinship relationship between the care-giver and receiver, the provision of care may or may not be done willingly or necessarily out of love and compassion. As Budlender (2004) has observed, some care-givers unwillingly provide care because, as women, they feel forced or pressured psychologically, socially, culturally or physically to do so.

From the above discussion, the quality of home care for the terminally or chronically ill person will therefore be assessed on the one hand from the point of view of the ability of a care-giving family to absorb and recover from impacts of illness, and on the other in the context of balancing or safeguarding overall family well-being. Resources could be derived from different forms of capital such as natural (renewable and non-renewable biophysical resources), produced capital (physical infrastructure and financial resources), human capital (individual knowledge, skills, labour and creativity), productive capital (farming and non-farming assets/ implements), institutional capital (public, private and non-government structures), and social capital (various types of formal and informal social networks that facilitate coordination and cooperation for mutual benefit) (Black *et al*, 2000). A resource or asset is simply anything that is of value in relationships with others and that contributes to capability.

Community and Family Care

According to Ogden *et al* (2004), concepts of care and support are usually applied interchangeably in home care literature. The use conflates clinical and non-clinical care and treatment, and emotional, spiritual and counselling support activities. We utilize the concept of care to refer to a full range of non-clinical activities undertaken by family members in the home (a non-clinical setting). The non-clinical care includes psychosocial support (spiritual and emotional) and custodial care (cooking, cleaning, feeding, helping with toiletry, ministration of remedies and treatment, nuanced elements of love and healing). Also included in the provision of non-clinical care are non-medical professionals and helpers such as social workers, faith-based groups and community volunteers. Medical attention is also provided in the family setting. However, treatment intervention provided by trained health professionals will be referred to as 'clinical care'.

Usually, as practice concepts, 'home-based care,' 'home care,' 'community care' and 'community home-based care' tend to be used interchangeably in the literature to refer to a universe of clinical and non-clinical service provision that is linked to the CHBC programme (Ogden *et al*, 2004; Jackson, 2002; WHO, 2002; Nokwane, 1993). Regrettably, for one reason or another, some home care provided either by family or community members is not linked to programmes. Ogden *et al* (2004) refer to this as 'unlinked' care. Too much focus on CHBC-linked service runs the risk of effacing unlinked care, especially in rural areas where HIV/AIDS-related service infrastructures and intervention programmes, such as voluntary testing, have not been put in place.

However, for purposes of analysis in this paper, home care is used to refer to a universe of clinical and non-clinical care providers who *are linked* to the CHBC programme in Maun village in Ngamiland. This includes both non-medical providers (family members, volunteers or neighbours) and health and social services professionals (from expert systems) who provide

varying forms of support to registered chronically or critically ill persons. Particular emphasis is placed on intra-family linkages of non-clinical care.

Practitioners across professions in human service organizations often take for granted the definition of a 'community' in 'community home-based care.' The notion of 'community' is used as a given to imply a seamless web of real or imagined clinical and non-clinical caretakers who may or may not be linked to formal and informal institutions. Also, in the community development literature, the existence of a 'community' simplistically assumes the presence of uncontested physical boundaries (natural bush, rivers, hills and other physical landscapes) that separates one social group from another. Clear social boundaries that exhibit common values and norms are also assumed. This definition is limited, since in their daily interactions people draw material and non-material resources from both a particular place and across territorial space and social identity boundaries. At times, the abstract notion of 'community' also tends to assume a household as a bounded place of faceless care-givers and recipients.

We prefer the concept of family rather than household, since, in the context of home care, household boundaries may be difficult to discern. In addition, the concept of household fails to capture social change dimensions of family structures (that is, family historicity). Without an historical context, family-based care-givers will be systematically and perpetually marginalized, since their existence is rendered oblivious to forces of social change. Also, the notion of co-residence does not adequately account for intra- and inter-family mobility, mutual obligations and the fulfilment of different socio-cultural functions (Guyer and Peters, 1987).

From the above discussion, we will borrow and modify for purposes of analysis Barrow and Murphree's (2001:27) definition of a community as a *principle* manifest in social groupings which has actual or potential cohesion, demarcated boundaries, and legitimacy to pool and manage resources within and beyond state intervention. Family and community boundaries (physical and identity) are malleable rather than static. Both structures influence, and are influenced by, human agency as well as inter- and intra-dynamic historical processes. In other words, both community and family members engage societal institutions (D'Hease and Kirsten, 2003). Family and community capacity, resilience and vulnerability depend on the ability of members to have a broader understanding of, and engagement with, a societal context. Additionally, we regard the concept of household inappropriate in the context of home care-giving. We prefer the concept of 'family' home care (FHC) broadly used to mean non-clinical care provided by individuals with kinship ties (either by descent or marriage), and normative obligations to care for (terminally or chronically) ill family members during a period of intense stress or crisis.

There is no watertight definition which would adequately incorporate membership principles and diverse cultural and historical experiences of family groups worldwide. Eichler's definition of a family is a social group that may or may not include one or more children, who may or may not have been born from a matrimonial union (cited by Collins, Jordan and Coleman, 1999:24). Looking at the diversity of living arrangements in contemporary Botswana, a family can also be regarded as a network of blood and non-blood related persons who have reciprocal social, economic and emotional obligations. The relationships among adults may or may not have origin in marriage, they may or may not be socially sanctioned, and the adults may or may not occupy the same residence and cohabit sexually. In other words, the viability of a family depends on interactive patterns, resource access and relationships which are premised on a particular cultural bias (shared beliefs and value system).

The conception of the 'extended family' in literature is convoluted. A narrow view of an extended family includes two or more families (grandmother with married son(s), his/their

wife(ves) and children). A broader view of the extended family would take into account various 'expansions' or forms of 'nesting' which include adult children, siblings, nieces/nephews, aunts, uncles, and cousins. Suffice it to say that extended family systems in Botswana and elsewhere in Africa vary in terms of membership principles, cultural diversity and historical experiences.

Research Setting

Maun is an urban village⁶ located at the base of the Okavango Delta, which is one of the major tourist attractions in southern Africa. During the past 30 years, Maun has experienced considerable growth both spatially and in terms of population size, largely due to migration from neighbouring rural localities (North West District, 2004). According to the national population census, 43,000 people live in the village (Central Statistics Office (CSO), 2002). Major economic activities in Maun include tourism, livestock keeping, arable farming, informal business activities, basketry, grass and reed (*letlhaka*) collection, and fishing and water lily (*tswii*) harvesting. Tourism-related commercial activities include guest houses, hotels, lodges, campsites and chalets; restaurants and fast-food establishments; craft outlets and retail, distribution and wholesale businesses; and various commercial banks and telecommunication facilities. Maun also has one of the busiest airports in the southern Africa region.

Administratively, Maun is divided into 15 wards (*dikgotla*). Each ward has a headman or chief, Village Development Committee (VDC), and several other village level committees such as those relating to health, water, education, animal health and the environment. Maun is one of the most ethnically diverse urban villages in the country, whose populace comprises Batawana, Bayei, Hambukushu, Baherero, Basarwa, Bakgalagadi, Basubya, Barolong and Baxhereku tribal groups.

According to the Botswana AIDS Impact Survey (BAIS II), Ngamiland District has an HIV/AIDS prevalence rate of 15% compared to 17% nationally. The survey also indicated that nationally about 6.7% of households reported having a seriously ill person, and 5.6% had experienced the death of at least one family member during the past twelve months (CSO, 2004). A study by Kgathi *et al* (2004) found that about 46% of sampled households in five villages in Ngamiland (Seronga, Gudigwa, Sehithwa, Shorobe and Etsha 6), reported the presence of chronically ill members in the preceding twelve months, some of whom had already passed away. Maun is one of the first four nation-wide sites to be identified for the implementation of the anti-retroviral drug therapy (ARVT) programme.

Research Design and Methods

This is a case study that explores the capacity of families to provide home care to HIV/AIDS chronically or terminally ill person/s in Maun. According to Yin (1984: 23), a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context. A case study approach is appropriate for this study since boundaries between the phenomenon and context are not self-evident. The unit of analysis is the individual home care-giver in a family setting. The relationship between care-giving activities and the context of care provision is complex, and therefore calls for multiple sources of data to be used. The case study design

6. The National Settlement Policy (1998) defines a village as a traditional settlement that is established on tribal land with a minimum population of 500 people. The 1991 Population Census defines an urban village as a settlement with a population of 5,000 or more persons with at least 75% of the labour force in non-agricultural occupations, an urban area is a non-agricultural commercial centre regardless of the population size.

enables the researcher to explore the complex process of access to resources within and across family and community relations.

Qualitative data was obtained through ethnographic methods, such as informal interviews and unobtrusive participant observations (Spradely, 1980; Bernard, 1995) which focused on care-giving family dynamic processes rather than an isolated event (Bell, 1993; Czaja and Blair, 1996). Informal interviews with key actors (community health nurses, social workers, family welfare educators (FWE) and volunteers) also were conducted. The care-giver's family provided a stage where different members play in a continuum of care-giving, ranging from that requiring the 'least' to the 'most' resources and social responsibility commitments. Individual life experiences provided nuanced responses to the research questions posed in the study (Fetterman, 1989; Weiss, 1994). Secondary data was obtained from electronic websites, published and unpublished government, NGO and CBO reports, and books and journals.

A pre-tested survey questionnaire was administered face-to-face to sampled home-based care-givers in Maun. The questionnaire covered relevant family resource capacity domains and the ability to cope with care-giving challenges. Five wards (Boseja, Thito, Mabudutsa, Boyei and Sedie) were randomly selected from a list of 15 designated wards in Maun. Following Bernard (1994), a simple random sample of 61 care-givers was selected from a list of registered CHBC service recipients obtained from the CHBC coordinating office, Department of Social and Community Development (SCD). In order to participate in the study, a care-giver had to be aged 18 years and above; live in the same household with the registered CHBC patient; be the primary care-giver or co-provider; and have served in the care-giving capacity for not less than three months.

The research design allowed for simultaneous collection of qualitative and quantitative data (Axin *et al*, 1987; Babbie, 1990; Bernard, 1995; Massey, 1987; Weiss, 1994) within a given population and social setting. Generalization of findings from this case study are particular to the care-giver population in Maun and do not represent a description of typical care-giving scenarios in Botswana.

Data Analysis

The unit of analysis in the study is the individual care-giver in the context of family and community relations. Qualitative data were analyzed through issue focus (Weiss, 1994) or thematically (Wuthnow *et al*, 1984). Quantitative data from the cross-sectional survey were coded, keyed and cleaned using the Statistical Programming for the Social Sciences (SPSS Version 12.0). Descriptive analysis in the form of frequencies and cross-tabulations was carried out.

Findings

Socio-economic Status and Care-giving

Female participation in home care is higher (91.8%) than male (only 8.1%). About 57% of care-givers were *de facto* single (neither married nor living together). Evidently, about 68.8% of care-givers are either *de jure* or *de facto* heads of their families. Family headship has implications for resource access and pooling. With regard to age distribution, 22% of the care-givers are aged 19-29 years, 47.5% are 30-40 years, and 14.8% 50-65 and above. The 19-49 age falls within the economically and sexually 'active population.' The educational level of care-givers in the case study is very low, which also reflects low levels of human capital development.

Approximately 19.5% of care-givers had no schooling at all, and about 50% had completed only primary schooling. The educational profile of their patients is not any better: about 36% had no formal education, 39% primary school, 14.8% junior certificate and 6.6 % had secondary education (see Table 1). Informal discussions indicate that care-givers require access to life-long learning and vocational skill development institutions. Unfortunately, access to non-formal education in Ngamiland, where it is clearly needed is still very constrained.

Table 1. Gender, age, education and marital status of care-givers.

Category	Frequency (N=61)		%	
Gender				
Female	56		92	
Male	5		8	
Age				
19-29	14		23	
30-49	29		48	
50-64	9		15	
65+	9		15	
Marital status	Gender		Total	%
	Female	Male		
Married	14 (22.9%)	0	14	(22.9%)
Never married	8 (13.1%)	1 (1.6%)	9	(14.7%)
Divorced/separated	1 (1.6%)	0	1	(1.6%)
Widowed	10 (16.3%)	1 (1.6%)	11	(18%)
Living together	23 (37.7%)	3 (4.9%)	26	(42.6%)
Total	56 (91.8%)	5 (8.1%)	61	(100%)

Data indicate that female patients constituted the majority (63.9%), the majority were aged 30-49 years and had primary level education (39.3%), and over half were married (50.8%) (Table 2).

Social Capital and Intra-Family Relations

In this study intra-family relations are considered to be an important buffer, as access could either enhance family strengths, resilience and the plausibility of recovery, or exacerbate conditions of vulnerability which may be characterized by severe deprivation. However, access to intra-family relations could be regarded as a necessary though not sufficient condition for a family to either experience rapid resource recovery or decline. Social relations cushion individuals and families against shocks and stresses by mediating the transfer or exchange of resources. Access to social capital in the context of HIV/AIDS care-giving consists of intra-family reciprocity networks (relatives) often extended through the life cycle. Reciprocity contributes to the maintenance of mutual support and prevents vulnerability in the long run.

Relationships of Support and Conflict

About 24.6% of care-givers cared for their siblings, 19.4% for their own children, 16.3% for their parents, 4.9% for their grandchildren and 3.2% for their spouses/partners. Care-givers received material and non-material support from various sources. Non-material support

Table 2. Demographic profile of care recipients.

Patient Background	N=61	%
Gender of Patient		
Male	22	36
Female	39	63.9
Patient Age in Years		
<18 years	6	9.8
19-29	10	16.4
30-49	36	59
50-64	3	4.9
65+	6	9.8
Level of Education of Patient		
No Formal Education	22	36
Primary	24	39.3
Junior Secondary	9	14.8
Senior Secondary	4	6.6
Tertiary	2	3.3
Marital Status of Patient		
Married	31	50.8
Never Married	4	6.5
Divorced/Separated	4	6.5
Widowed	16	26.2
Living Together	6	9.8

includes home visits (*gō tlhola molwetsi*), companionship (*go ntsha mooki le molwetsi budutu*), prayer (*thapelo*), or 'to talk' (*go bua*). Material support includes provision of food (maize meal, sugar, tea, fruit, meat or vegetables - *sehabo*), taxi fare and transport to and from the hospital. Access to material support such as the provision of food or transport money is important in reducing the risk of depleting food and financial resources.

Overall, the majority of care-givers are most likely to receive non-material support compared to material support. However, most patients who live with their partners (living together or married) receive material support (73.7%) from their carers. Generally, care-givers have multiple sources of support from close family members such as their own children (72.5%), their siblings (64.9%), own parent (63.9%), spouses (63.6%), parents in-law (41.4%) and from the extended family (33%). The importance of the immediate family was highlighted by one respondent, who said, 'Only your children are your relatives nowadays; relatives do not want to take care of patients any more.'

Socially, care-givers said that the provision of non-material support minimizes social isolation, hopelessness and stigmatization, and cultivates a sense of hope, optimism and resilience. Table 3 below gives a summary of the sources of material and non-material support for care-givers.

Care-givers were asked informally to suggest areas in which they require support. The majority tend to require the provision of instrumental labour such as doing laundry; bathing, dressing and feeding the patient; picking up food from the market or medical supplies from the hospital or clinic; and family upkeep activities (fetching water, collecting firewood, cleaning the

Table 3. Intra-family support.

Care-giving Relationship	Yes	No	Material (%)	Non-Material (%)
Siblings	64.9	35.1	21.6	78.4
Children	72.5	27.5	15.8	84.2
Spouse	63.6	36.4	73.7	26.3
Parents	63.9	36.1	23.8	76.2
In-laws	41.4	58.6	25	75
Relatives	33.3	66.7	18.2	81.1

yard and homes). Since care-giving tends to be location-bound, and to prevent or restrict care-giver mobility, access to intra-family labour resources would free the care-giver to engage in formal or informal resource-building activities, and is therefore a significant factor in enhancing family resource capacity.

Conflict characterizes care-giving relations and processes as do relations of collaboration and mutual support. About 70.8% of care-givers reported strained social relations with their patients. Conflict could stem from a range of sources including temperament, fatalistic practices such as alcohol abuse, and prior acts of family desertion of the care recipient. About 16.7% of care-givers reported intense conflict and increased distance between and among themselves, the care recipient and other family members. Of these care-givers, 8.3% sought outside intervention from professional service providers. In situations where the threshold of relationship tolerance is very low, family members either disband and go in different directions, or still share the same compound but resort to physical or emotional abuse. The family group may also fragment into numerous 'units,' each fending for itself. A fractured family configuration display 'enclave-like' social and structural relations. Members co-exist, but are most likely to be 'disengaged' from each other, and the relationship with the care recipient can be characterized as abusive (emotionally and physically).

The most extreme form of conflict occurs when the care recipient physically assaults the care-giver. Also the care recipient may be tossed from one care-giver to another for various reasons. In fact, when care-givers were asked whether the person they cared for has ever moved, 32.8% said 'yes.' These care recipients stayed with relatives (94.1%) rather than their parents (9.5%). Informal interviews suggest that where intra-family relations are very fragile, the care recipient is likely to be abandoned or to become destitute if external agents do not intervene in a timely manner. Care giving can make a bad situation worse by intensifying pre-existing intra-familial conflict. In conflict-ridden scenarios, negative talk and elements of fatalism, such as alcohol abuse or suicidal ideation, are most likely to be observed, either among care-givers or patients themselves. Both tend to place less value on their life, are pessimistic about the future and overwhelmed by daily problems.

However, the severity of conflict is influenced by several factors. Alcohol abuse by care recipients was cited during informal interviews as likely to make a bad situation worse by increasing personal isolation and social distance between family members and the community. Gender, educational attainment and length of care were also observed as factors contributing to strained care-giver/care recipient relations. Although the majority of care recipients are females (63.9%), and only 36% were males, aggressive disposition toward care-givers was reported mostly by female care-givers of male care recipients. Educational attainment was observed as influencing the intensity of conflict, especially in a situation where some cultural expectations equate a given social status (being a formally employed daughter-in-law or *ngwetsi*) with self-

sacrifice or effacement of individual well-being. In this scenario, family members may expect the care-giver to meet both material and non-material needs of the care recipient.

Intensity of conflict also depends on the length of care provision. About 18% of care-givers provided care to the same person for one year or less, 9.8% for two years, 29.5% for three years, and 25.5% for four years or longer. Continuous care-giving is likely to take its toll on the well-being of the whole family, not just on the care-giver, thus increasing the chance for intra-familial conflict. Also, those who have provided care-giving to numerous patients are also likely to have experienced one or more deaths over time, and thus increased stress. Overall, about 54.2% of care-givers said they were either avoided or ignored, and 25% said they just endured the situation. Table 4 gives a summary of the length of care-giving.

Table 4. Length of care-giving.

Length Care Provided	N=61	
< 1 year	11	(18%)
1 year	11	(18%)
2 years	6	(9.8%)
3 years	18	(29.5%)
> 4 years	15	(24.5%)

About 40.4% of care-givers acknowledged that they experience both positive and negative relations with care recipients, and only 4.2% of care-givers reported to have become closer to care recipients. The positive factors included emotional aspects such as closeness/love, and subjective acts of mutual cooperation in optimal pooling and the utilization of scarce resources (food and money).

It was observed that close kinship relations between the care-giver and the recipient also appear to be important in nurturing cooperative relations. Maria (not real name) from Boseja ward, for instance, who was the youngest of seven siblings, cared for her older brother (*mogo'lle*). The patient had failed to cooperate with the voice of male authority from his older brothers and uncles, especially on matters of personal hygiene. Maria took it upon herself to insist that he eat properly, adhere to medication, and return to work after reasonable recovery. Maria accompanied her brother for HIV pre-test and post-test counselling, helped him to enroll in the ARV programme, and registered him to procure the CHBC food basket. When the brother was 'down and out' she was always there with and for him, encouraging him not to give up. She played the key role of medication 'buddies' (*mompoti*) and put pressure on her older brothers to provide sufficient food for him. Availability of food resources enabled Maria to monitor the nutritional status of her brother. Maria relied on access to a working radio to help her sick brother adhere to the ARV schedule. Maria's patience paid off. Her brother's status changed from loss of employment and being 'down and out' to being employed, healthy and mobile.

When asked how she was able to assert herself so strongly, Maria indicated that she and her brother had been very close since childhood. She thus played the 'baby sister card' as well as expressing genuine love and empathy towards him. Maria not only took over the role of care-giver for her older brother, she was also instrumental in reducing the risk of her brother becoming a jobless dependent after recovery. She became the anchoring point for all family members who felt a sense of social responsibility not only to the patient, but to provide support to the dedicated but also unflinching 'baby' of the family. Although the feelings were reciprocated,

cated, Maria still needed the 'body power' of her older brothers and uncles for bathing and shaving the 'unkempt beard' of her sick brother.

Conflict ridden care-giving relations, however, should not be taken to mean that extended family relations have 'broken down'. Rather, what is important to observe is the elasticity of these very weak ties, and the extent to which they still provide a safety net for individual members. The 'family', extended or not, does not necessarily exist as a corporate entity. Individuals negotiate kinship relations in various ways in order to galvanize some willingness to commit resources (material and non-material) to care-giving responsibilities. For instance, although non-material support is most likely to be available, at least 21.6% of care-givers received material support (cooked food, maize meal, sugar, tea, fruit, meat, taxi fare and transport to take the patient to the hospital) from their siblings, children or parents.

It is worth pointing out that although less attention has been given to live-in partners, they also seem to be playing a crucial care-giving role. During an informal interview with "Keletso", a 22-year old care-giver, she indicated that she received more support from her live-in partner after the death of her parents than from her siblings and relatives. She is also a *de facto* family head, providing care to a nine year-old sister who is terminally ill. However, some care-givers are quick to point out that their relatives are most likely to be unemployed and are in fact worse off economically than themselves. Furthermore, although other care-givers acknowledged support, several stated that support from relatives is often irregular, has too many strings attached (*dingalo*), and therefore tends to be very stressful.

Relations of mutual obligation and shared responsibility tend to reduce vulnerability, and the family becomes a safety net by pooling limited resources. However, if care-giving is most likely to precipitate adversarial rather than collaborative intra-family relations, then the ability of a family to mobilize its resources, especially access to intra-household labour, is compromised. Overall, a care-giving relation which emerges from the data suggests 'imperfect' or ambiguous 'obligations' rather than unbridled altruism. Also, non-material exchanges are not insignificant. On the contrary, they tend to strengthen family resource capacity and improve its level of emotional and spiritual functioning.

Access to Production Capital

Arable and Livestock Farming

Although care-givers affirmed during informal interviews that arable farming contributed to family food security, about 69.5% of the care-givers indicated that they were not engaged in arable farming as a source of livelihood. Poor rains and recurrent drought were identified as major problems. With regard to arable farming implements, only 26.2% had ploughs and 17.7% a donkey cart (see Table 5). At least 72.1% of the care-givers had access to a cluster of hand tools such as an axe, pick, hammer, spade, rake or fork; 41.0% to a wheel-barrow; 11.5% to large plastic drums; 23.0% to large metallic drums, and 18.0% to large cooking pots. A donkey cart is a multi-purpose asset. It is generally used to transport inputs and outputs from farm and non-farm enterprises, such as construction material, firewood, water and other household items. Families without a donkey cart or motor vehicle are clearly at a significant disadvantage. Young persons aged 19-29 years are less likely to own donkey carts (18%), and those aged 30 years and over are likely to own a donkey cart (80%).

With regard to livestock ownership, only 21.3% owned cattle, 31.1% had donkeys, 41.9% had a few goats/sheep, 32.8% had poultry birds and 9.8% had horses (see Table 6). In part, low levels of livestock ownership could be attributed to the fact that Maun is an 'urban

Table 5. Ownership of production assets.

Type of Asset	Own	%	Not own	%
Donkey Cart	11	18	50	82
Motor Vehicle	6	10	55	90
Wheel-barrow	25	41	36	59
Axe/Pick/Spade/Fork	44	72	17	28
Large Metal Drums	14	23	47	77
Large Plastic Drums	7	12	54	89
Plough	16	26	45	74
Large Cooking Pots	11	18	50	82

Table 6. Ownership of livestock.

Type of Livestock	Own	%	Not Own	%
Cattle	13	21.3	48	78.7
Donkeys	19	31.1	42	68.9
Goat/Sheep	26	41.9	35	57.4
Poultry	20	32.8	41	67.8
Horses	20	9.8	41	67.2

village', hence families have difficulty manning cattle compared to small stock. In 1995, the entire district cattle herd was eradicated due to CBPP (*Contagious Bovine Pleuro Pneumonia*) or cattle lung disease.

In addition, only 10% of people in the district ventured into small stock production through the Financial Assistance Policy (FAP) (North West District Report NWDC, 2003). Small stock, such as sheep and goats, are less labour intensive, are more drought resistant, have a high regenerative capacity, and can be sold locally quickly in case of a family emergency. However, some care-givers abandoned their small stock raising activities because of care-giving. As one care-giver put it,

I left my goats with the herd boys at the cattle post (*moraka*) and many of the goats have gone missing. I was the only one who could provide care to my young sister and her daughter. When she recovered, my goats had already gone astray.

Home-Enterprising Opportunities and Disposable Assets

Ownership of various consumables can be used as a proxy measure of access to disposable income. In monetary terms, hand tools such as an axe, pick, hammer, spade, rake and fork are affordable. These implements are basic to daily household activities, such as chopping firewood, fencing plough fields and cleaning the yard. However, given the high rates of unemployment in Maun, the availability of these household tools can be translated into impromptu seasonal income generating assets. Wheel-barrow, large cooking pots and metallic drums require more money, and their utility outside the household is also diverse (such as renting them out during weddings and funerals, when there is demand for large quantities of water and food preparation and transportation of bulky items). A spade, rake and fork come in handy, for instance, during the rainy season when there is demand for labour to weed grass, especially in

high- and middle-income courtyards. An axe or a pick is useful for felling fencing poles and cutting wood for sale (especially to tourist campers in Moremi Game Park in the Okavango Delta). A hammer is generally used for crushing stones for sale to small construction companies. Large drums (metallic or plastic) are used to collect water 'for sale'. Families with a wheel-barrow, donkey cart, trailer or open truck collect and sell water to families who live on the outskirts of Maun at the cattle post (*moraka*).

Care-Giving and the Depletion of Family Resources

Some care-givers had disposed of their assets to generate money for medical bills and for purchasing foodstuffs and other care-giving necessities. About 60.7% of care-givers indicated that care-giving had a negative financial impact, while 37.7% said they felt no change at all, indicating that they had no money to spend anyway, and as such it would be difficult to measure such effects. About 45.5% depleted their savings and 32.2% their food reserves, 13.2% sold their assets and 6.6% their livestock, while 1.6% incurred debts through borrowing (Table 7). Furthermore, about 66.7% abandoned their income-generating activities and 24.2% farming, 15.2% embarked on some home enterprise, 9.1% were 'just overwhelmed', and 21.2% had 'nothing to do' (Table 7). Care-giving is often full time work which may conflict with other work. As one care-giver explained,

You cannot combine care-giving and work. I wait for the children to come from school, when they arrive, they open the tuck-shop while I continue providing care.

Table 7. Care-giving resource impacts.

Effects	Frequency	%
Depletion of funds	28	45.5
Shortage of food	20	32.2
Sold assets	8	13.2
Sold livestock	4	6.6
Debt	1	1.6
Total	61	100.00

Table 8. Impacts of care giving on aspects of family well-being.

Impacts on Family well-being	Frequency	%
Abandoned Income generating activities	22	66.7
Abandoned farming	8	24.2
Depressed	3	9.8
Coping		
Depended on patient ration	8	24.2
Depended on handouts from people	7	21.2
Part-time business	5	15.2
Old age pension	6	18.2
No option/ "nothing to do"	7	21.2

As indicated earlier, the majority of care-givers own very few arable and livestock productive assets. The difficulty of recovering from the financial impact of care-giving is evidenced by the fact that 81.4% of care-givers said that they could not do anything to recover or reverse the loss, 14.8% had been forced to depend on handouts, and only 2% took up self-employment activities such as opening a tuck shop or taking a 'piece job.' The coping mechanism included falling back on government safety nets such as old age pension, the CHBC food basket and voluntary acts of compassion from the community.

Produced Capital

Access to HIV/AIDS institutional infrastructure in the fields of health and social welfare services is an asset. Maun residents have at their disposal a Voluntary Counselling and Testing Centre (VCT), and several clinics offer the Prevention of Mother-to-Child Transmission (PMCT) programme. Strategies for enhancing access to knowledge as a means of preventing HIV infection, especially for women and adolescent girls, include education, health services, media campaigns, behaviour change, life-skill building and job training. Access to institutionalized prevention services therefore enables individuals and families to reduce risks of infection and plan for the future.

Provision of Information and Communication Technology (ICT) and transport infrastructure, such as telecommunication (radio, television, personal computers (PCs), fax machines, internet cafes, satellite dishes, etc.), is critical in the context of HIV/AIDS prevention. Access influences the ability of a family to respond to a crisis, and renders members either more or less vulnerable compared to others in a similar situation. Maun, as a district headquarters, is well endowed with various sources of information and communication. These include newspapers, magazines, radio stations, television, internet cafés, computers, fax machines, radios, post offices, and transport and telecommunication infrastructure. Some residents of Maun also have access to government and privately owned newspapers, which are written in English and Setswana. There are also numerous privately owned weeklies such as the *Mid-Week Sun*, the *Gazette* and *Morongwa*, and dailies such as *Botswana Daily News*, *Ngami Times* and *Mmegi/The Reporter*. As we have already pointed out, the low literacy rate of care-givers excludes them from accessing information in the printed media. However, the majority can read in the local language, Setswana, and some newspapers are written wholly or partially in Setswana. *Morongwa* is the only private newspaper which is 100% Setswana. While all the other newspapers cost about P2.00 the *Botswana Daily News* is free. Access to a public library is also free.

Physical mobility through public transport is also an important resource for care-givers. Data from the public transport office in Maun indicated that there were 60 taxis and 126 mini buses which provide internal public transport. In addition, 32 buses provide long distance connections between Maun and other towns (such as Francistown and Gaborone) and villages. Maun also has an airport, one of the busiest in southern Africa. An interview with a Botswana Telecommunications Corporation (BTC) officer indicated that Maun has approximately 5,217 telephone connections, about 25 public coin booths and several internet cafés.

Radio is the most important Information and Communication Technology asset for households in both urban and rural communities in Botswana. Almost 68% of families in the country own a radio (CSO, 2002; Government of Botswana & UNDP, 2005). Radio Botswana transmitters offer FM and medium wave coverage in the main towns in the country where most people are located. Radio dramatizations are broadcast in Setswana and reach out to most parts

of the country. A significant proportion of care-givers indicated that they have access to a radio (61%), cell-phone (48%), television (23%) or landline telephone (31%) (Table 9). Thousands of people in Maun have regular access from street vendors to cell phone services including the provision of phone cards. Access to a phone (land line, cell or public booth) is particularly critical during medical emergencies.

Table 9: Access to telecommunications.

Telecommunication	Own	Do not own
Television	14 (23%)	47 (77%)
Telephone (Land line)	19 (31%)	42 (69%)
Cell phone	29 (48%)	32 (53%)
Radio	37 (61%)	24 (39%)

Most rural communities cannot afford electrifying their homes and use dry-cell batteries. Access to a working radio is especially significant since it is the major tool for disseminating basic information about HIV/AIDS and for informing the public about government programmes. As we previously indicated, Maria relied on her radio to help her sick brother adhere to the ARV schedule. Care-givers with good radio access were more likely to listen to radio programmes. Infrequent listening was more likely to be attributed to poor radio access than any other factor.

The study on Community User Information Systems in rural areas undertaken by the Botswana Technology Centre (BOTECH, cited by GOB and UNDP, 2005) revealed that communities rated telephones as the most important communication tool. About 27% of the Botswana population has access to a number of local internet points. Botsnet provides dial-up access to local telephone. As a result, a further 60% of the population could potentially have access to the internet. However, access to the internet through cyber-cafes is typically P10.00 per hour, a cost that further widens the internal digital divide in Botswana.

Discussion and Conclusions

The 19-49 year old age group constitutes the majority of care-givers who are in fact in the economically and sexually 'active population.' This finding contradicts the notion that HIV/AIDS is the 'grandmother disease' (Phaladze, 2001), which implied that aged grandparents shoulder the burden of caring for the sick and dying. In this study, home care for HIV/AIDS patients is less likely to be provided by older persons whose immune and health systems are already compromised by age. Rather, in the Maun case study, it is the 'active population' of persons in their most productive years that constitutes the largest single group of care-givers. The disease impacts are 'cohort implosive', meaning that relationally, either as a mother, sister, brother, son or daughter, this group carries the heaviest infection/affliction, morbidity/mortality, and care/loss/grief burdens.

There has been a rapid reduction in Botswana of the percentage of people who have never been to school due to the phenomenal expansion since Independence of the education infrastructure in the country. The Revised National Policy on Education (1994) provides for universal access to education and improvement in vocational training. The recent Botswana Literacy Survey (2004) indicates that 81% of Botswana aged 15 years and over are literate (80% male and 82% female). However, disaggregated data by district and gender reveals differences

in attendance rates at primary and secondary schools. According to the 2001 population census (CSO, 2002), 13.2% of males and 10.7% of females in urban centres have never been to school, whereas in urban villages (such as Maun) 24.5% of males and 19.4% of females have never been to school. In rural villages 33.9% of males and 31.9% of females have never been to school.

From the above discussion, the Botswana government's investment in human capital development is commendable. In addition, Maun, as an administrative capital, has a well developed infrastructure of educational institutions (three Senior Secondary Schools (one public and two private), six Community Junior Secondary Schools, twelve Primary Schools, one Vocational Training Centre, and one Brigade). Compared to the national average, although Ngamiland East (where Maun is located) has an 89% literacy rate, males tend to figure higher (90%) than females (87%) (Botswana Literacy Survey, 2003). Yet the majority of care-givers reflect low educational attainment (19.5% had no formal schooling while 50% had completed primary school only). Unfortunately, basic literacy in Botswana is no longer as influential as secondary education in determining family financial well-being and access to employment opportunities. Even those who have reached junior certificate (JC) level find it hard to participate in the labour market. Furthermore, senior secondary schools admit only 50% of JC graduates, with the remaining 50% expected to pursue vocational training or join the ranks of unemployed youth.

The critical issues for care-givers therefore seems to be access to continuing vocational education in order to improve not only functional literacy skills, but also the income earning capacity of care-givers. Data from the Department of Non-Formal Education (DNFE, 2004) indicate that there were 31 functioning literacy groups in Maun. Informal interviews with an officer in the DNFE in Maun suggested that learners in these literacy groups tend to excel in mathematics and Setswana (the local language). It goes without saying that education contributes to improved economic opportunities besides enabling the empowerment of individuals. Care-givers are trapped by an education and economic system which, instead of expanding shrinks their capability or earning opportunity space. Also, Mahal (2001) argues that there is evidence of links between achievements in human capital development and the effectiveness of policies to prevent HIV transmission. Education matters not only in market competitiveness, but also in awareness about infection risk and the availability of HIV/AIDS service infrastructure.

Information Communication Technology empowers human capabilities. A study of 'Village Pay Phones' in rural Bangladesh (Richardson, Ramirez and Haq, 2000), for instance, suggests that access improves women's social mobility and work participation, and also empowered involvement in family decision-making matters. Although access to telecommunications does not mean that care-givers would have home care work, it implies that ICT enhances information acquisition, knowledge development, sharing and connectedness among care-givers, institutions and resources.

The female gender bias in care-giving responsibilities in this study is consistent with the UN Secretary General's Report (2004), which revealed that two-thirds of care-givers in southern Africa were women. Nonetheless, it is worth noting that men may be slowly changing their attitudes towards care-giving. For instance, in a recent Radio Serial Drama Listenership Survey, *Makgabaneng* (BOTUSA, 2005), 83% of males aged 15 to 24 years, and 90% of males aged 25 to 49 years, said they could care for an HIV-positive extended family member. The findings of *Makgabaneng* study notwithstanding, the perceived willingness to carry out the drudgery of home care (such as cooking, cleaning, feeding, and attending to the sanitary needs

of a patient) and the administration of over-the-counter and herbal remedies (Akintola, 2003; Berman, 2002; Steinberg *et al*, 2002; WHO, 2002) by males within the gender family division of labour, needs further empirical research.

The prominence of female 'headship' in home care has implications on the 'feminization of poverty.' In other words, care-givers as women tend to experience numerous processes of resource deprivation in more specific ways than men (BRIDGE, 2001). A caveat to female headship and the feminization of poverty is that female-headed families are not homogeneous and necessarily poor. Some household head care-givers may be able to strike the balance between paid and unpaid work, and as such may have greater control over their finances, and experience less physical or emotional abuse. Other household head care-givers may be unable to take up paid work and provide unpaid services. These are likely to have less access to a wide range of resources. What is important to emphasize is that women in Botswana, like elsewhere in the world, face triple threats of gender inequality, poverty and HIV/AIDS (UNAIDS/UNFPA/UNIFEM, 2004). As more people die from AIDS, women are burdened with care and sink deeper into poverty. If family resource capacity continues to be taken for granted, and care-giving responsibilities on women and girls continues to increase unabated, the trend could reverse the development gains made in past decades. Moreover, care-giving is often thought of by policy-makers and programme-implementers as the fulfilment of 'gendered social roles'.

Home care work remains unpaid and therefore undervalued in economic terms (UNAIDS/UNFPA/UNIFEM, 2004). Until recently, little attention has been given to the fact that home care for the terminally or chronically ill constitutes unpaid care work. At the macro levels poverty reduction strategies and national AIDS plans in Botswana seldom take women's care-giving into account. Social services practitioners romanticize home care as altruistic self-sacrifice by benevolent family members. Policy-makers assume that unpaid work is in limitless supply, but as Budlender (2004: 37-38) points out, there is a limit to unpaid labour if suppliers (mostly women and girls) are pushed too far and the burden placed on them becomes too great. Although one objective of CBHC is to provide quality to care recipients, family resource capacity determines quality. With limited access to resources, the quality and amount of care that families can provide will continue to deteriorate.

Care-givers, mostly women and girls, provide services which involve externalities (third party effect) (Ogden *et al*, 2004). According to Budlender (2004), positive externalities bring benefits and negative externalities impose costs on other people. Since unpaid care work is often bound to a particular location, its provision therefore restricts the movement and activity options of the care-givers (opportunity cost), and consequently excludes them from engaging in productive activities inside or outside the household. Women's roles in the care economy therefore tend to intensify their poverty and livelihood insecurity. A large proportion of them already have meagre incomes, which are then used to support care-giving. Increased workload, loss of family income and deepening poverty make care-givers become dependent on others.

The Botswana government has demonstrated the political will and commitment to target resource allocations that will enhance HIV/AIDS survival strategies for afflicted and affected individuals and groups. However, political will appears to be in short supply when it comes to recognizing the fact that care-giving thus exacerbates gender inequalities and the 'feminization of poverty', and perpetuates structural injustice in the broader context of the care economy⁷

7. There are three kinds of non-market work which contribute to sustaining the fabric of society, especially in the sense of civic responsibility. These are subsistence goods (such as food, clothing, pottery, and crafts), household care (such as cooking and cleaning), and voluntary local or national civic associations and self help groups (both secular and church based).

(Budlender, 2004; Elson, 1999, 2002; ILO/UNIFEM, 2001). According to Alkire (2004), structural injustice arises when institutions are designed to further some interest, but harm or cause to constrain certain capabilities or opportunity costs. The burden of home care on women fails to evoke political will and commitment to allocate resources that would capacitate families and strengthen intra-family relations.

Care-giving is a public service which not only requires the use of scarce resources, but also has the potential of either reducing or increasing family vulnerability⁸. Family resources or assets could be depleted to the extent that even an upturn of events would not reverse the damage. When their resources are depleted and they are disengaged from external support systems, family members cease to give each other support. Family livelihood⁹ options are enhanced when members receive support from others in the community. This in turn enables them to cope and provide support to each other. Intra- and inter-family links, therefore, consist of a complex exchange of positive and negative feedback, of relations of reciprocity and mutual obligations, of plural allegiance and alienation, including virtue and vice. A care-giving family can avoid or reduce vulnerability not only on the basis of initial assets, but also on the ability of members to transform (either by intensifying existing strategies or through the development of new strategies) these capabilities (in this case, intra-family, productive and produced) into marketable skills, knowledge, income, food or other basic necessities.

Although the extended family in Botswana and elsewhere in Africa has been severely impacted by forces of social change, some scholars have argued that the family values appear strong (Weisner *et al*, 1997). What is central to persons afflicted by the HIV/AIDS pandemic is that the provision of home-based care occurs within diverse family structures and value systems in a given historical and cultural context. Inter-family linkages could fall within a continuum of functioning. In the pre-HIV/AIDS period, families and communities in Botswana, like elsewhere in Africa, provided social protection. To some extent, family members depended on the viability of productive systems to secure resources or assets, and to help them live with and beyond a shock. However, social relations are still defined by kinship practices and ideologies, and members are generally expected to contribute material or non-material resources, in some situations, for instance, during critical illness or death. Sibling groups play a significant role during stressful events and tend to work collaboratively.

Policy Recommendations

1. Direct support resource capacity building should be given to home care-givers, and community based projects should hire trained volunteers to provide respite support to care-givers;
2. Training and continuing education programmes should be targeted at enhancing the marketability of home care-givers, and support for male care-givers should be initiated; and
3. The coordination of efforts by institutions that provide care and support for home care need to be strengthened.

8. Vulnerability is insecurity and the responsiveness or resilience of individuals, groups and communities in the face of changing environments (these could be macro- and micro-ecological, economic, social, cultural and political) (Moser, 1998:3).

9. According to Ellis (2000), a livelihood comprises of a range of forms of capital or assets (natural, physical, human, financial and social).

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