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CAREGIVING ON THE EDGE: FAMILY CAREGIVING OF THE ELDERLY IN BOTSWANA

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ABSTRACT

CAREGIVING ON THE EDGE: FAMILY CAREGIVING OF THE ELDERLY IN BOTSWANA

Sheila Shaibu, R.N., Ph.D

Little is known about long-term care of the African elderly. The assumption in Botswana, as in many other African countries, is that families support their own elderly relatives. The goal of this study was to investigate the experiences and needs of the family caregivers of the elderly. Grounded theory methodology was used to interview 24 participants individually and in four groups. The participants were recruited from two rural areas, Shoshong and Kalamare, and Gaborone, the capital city. The mean age of the caregiver was 49 years and that of the care receiver was 81.7 years. The mean length of caregiving time was 5.4 years.

Findings from this study indicate that caregivers were giving care on the edge because of the interacting tripartite processes within which caregiving occurred. Caregivers were on the edge of survival as they struggled to meet basic needs such as food, shelter, and sanitation, in spite of their poor socio-economic conditions. Caregiving was located in a changing socio-cultural milieu where some of the families were in transition from a collective system to an individualistic family system. Family roles were changing and new gender roles which were structured by the family systems were exemplified by male caregivers who were taking care of their parents.

Caregivers were also on the boundaries of health care system. They faced problems of transportation to the clinics and hospitals, lacked money for consultation, faced ageism from health workers and were adversely affected by lack of home based services targeted at the elderly. Linking these processes are the strategies of negotiating, resisting, mobilizing, and questioning. Many hardships were silently endured by both male and female caregivers who suffered adverse consequences in the course of caregiving to their relatives. These findings can be used to develop social programs and health programs for the elderly.

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CHAPTER 1

THE STUDY PROBLEM

Introduction and Background

The global population growth rate for persons 60 and over is 2.5% per year. Eighty per cent of this increase is in developing countries, where the rate of growth is nearly three times that of developed countries (PAHO, 1990). United Nations (1991) estimates for 1990 indicate that 56% of the world's population 65 and over already lives in less developed countries. In addition, there are increasing numbers of the oldest old. In the United States, those aged 85 and over are the fastest growing sector of the aged population, and it is projected that they will comprise 40% of the elderly population by the year 2030 (Rice, 1986). In Botswana, until recently, deaths from infection and accidents kept down the number of frail aged (Staugard, 1985). However, since the adoption of a clinic within 15 kilometers of every village as a Primary Health Care strategy, the numbers of frail elderly have increased (Ingstad, Bruun, Sandberg, & Tlou, 1992). Life expectancy has increased from 55 years in 1980 to 61.7 years in 1991 (Ministry of Finance and Development Planning, 1991). It is projected to reach beyond 65 by 1995, and to attain the rates projected for North America by 2020 (United Nations, 1985).

Presently the aged comprise approximately 5% of the Botswana population (Central Statistics Department, 1991). While this may seem small, this number has more than doubled in the last twenty years (see Table 1-1). In 1985, the majority of the population (80%) resided in the rural areas (Central Statistics Office, 1988). The female survival advantage prevails in Botswana for the age group 65 years and over. A consequence of this change in demography of the population has been an increase in the number of elderly persons with functional disabilities and chronic impairments (Biegel, Sales & Schulz, 1991).

Table 1-1

The Demographic Profile of the Elderly in Botswana

	1981	1991
Total Population	941 027	1 327 638
Population Aged 65+	43 193	62 531
Males 65+	18 577	27 844
Females 65+	24 616	34 647
Life Expectancy	56.2	61.7

Concern about these changes and the potential health consequences resulting from increasing number of elders dates back to the early eighties. The United Nations convened the World Assembly on Aging in 1982 as the social dilemma of increased life expectancy and decreased quality of life for the aged was becoming an international concern. The rationale of the World Assembly on aging was to promote forward looking policies in order to anticipate and respond in a timely manner to the far-reaching socioeconomic implications of the demographic shift (Kelley, 1985).

In Botswana, although the population of the elderly is steadily increasing, there does not seem to be an acknowledgment or awareness of the fact that families' needs evolve as society changes. No one is preparing these families to assume the role of caregiver, or assessing if they are adequately coping with this role. Part of this continuing lack of awareness can be attributed to a lack of accurate data needed to formulate policies and programs (Litvak & Maggi, 1991).

Statement of the Problem

The demographic shifts toward an aged population have heightened the caregiving needs of the elderly on a global scale (Biegel & Blum, 1991). Yet, very little is known about long-term care of the frail African elder (Cattell, 1993). The assumption in Botswana, as in many other African countries, is that families support their own relatives. For a long time there has been a belief that the extended family is capable of rendering virtually insignificant the problem of aging. Currently, there is no substantial empirical evidence to support views contrary to this (Apt, 1993). Therefore, precisely who the caregivers are, their needs, and their satisfactions or difficulties need to be established.

In light of the changes that are occurring in the country due to both industrialization and urbanization, migration, declining fertility rates, and the poor socioeconomic status of the elderly, it is important to assess the experiences, needs and characteristics of the caregivers of the elderly in order to plan programs for this age group and their caregivers. Given the disabling effects of chronic illnesses that accompany aging, families require help and knowledge to assist them in the care of the elderly persons.

Societal and environmental changes that have an impact on the elderly include poverty, declining fertility rates, and rural to urban migration. Each of these forces create concomitant alteration of the family structure. Prolonged droughts have exacerbated the urbanization process, as well as lack of employment opportunities in the rural sector. Consequently, elderly people and grandchildren are most often left in the villages.

With the social changes that Botswana is undergoing, it is increasingly difficult for families to provide the care required by an increasing number of elderly persons. Yet there are no programs to support the elderly in Botswana (Mugabe, 1994; Osman, 1983). It is important for nursing to be aware of the changes in the environment in order to implement appropriate interventions.

Significance

Although elderly people comprise 5% of the Botswana population, their increasing numbers mandate that social policies be established now before a crisis occurs. To date, most of the research in Botswana has focused on the effects of social change on the elderly. By contrast, this study will focus on the experiences of family caregivers who are providing care.

The role of the family in the care of the elderly globally has been well documented. The situation of the Batswana elderly in the face of the social changes has been depicted as worrisome (Guillette, 1990; Ingstad, Bruun, Sandberg, & Tlou, 1991). However, in Botswana, little research has focused on the family caregivers of elderly people. If the role of the family as a support system to the elderly is to be strengthened, it is important to establish who the family caregivers are and what their precise needs may be.

Knowledge development regarding family caregiving in Botswana is integral to designing future health programs which will be cognizant of families' experiences, because the trend of aging and social changes will continue to render family care of the elderly complex. The researcher hopes to provide findings that will influence and direct policy for the elderly. The theoretical formulation that results can be used to explain reality as well as to provide a framework for action (Denzin, 1994) that is culturally appropriate.

There are many models of assistance to the elderly in western countries. Although the ideas themselves can be copied from one country to another, the socio-cultural, political and economic environments which support them cannot be imported. They may serve as useful examples of how particular problems were addressed in some countries, but cannot be transplanted and expected to thrive (Kalache, 1991).

Therefore, it is necessary to conduct research specific to Botswana, and establish programs that are relevant to and viable within the existing cultural, social, economic, and political structures. Knowledge that evolves from the socio-cultural and economic contexts will more realistically influence health care policies (Meleis, In press).

Health care in Botswana is based on the Primary Health Care concept, and Health for All by Year 2000 is an internationally recognized goal to which Botswana also aspires. However, the fact that this "All" includes the elderly population is sometimes overlooked as is shown by the lack of health programs for this age group in Botswana (Osman, 1983). The neglect of this population is probably due to a lack of awareness of the phenomenon of aging, and its concomitant health problems.

Developing countries have limited capacities for planning for the consequences of a rapidly increasing aged population when they are still facing problems associated with their younger populations (Litvak & Maggi, 1991), usually with limited resources. Currently the Botswana health care delivery system focuses on health promotion and treatment of childbearing women and children. This is evidenced by an infant mortality rate which has decreased from over 100 per 1000 to 37.8 per 1000 (Ministry of Finance and Development Planning, 1991) as a result of free health care for these age groups, emphasis on the Expanded Program on Immunization, and the Oral Rehydration Program.

This approach is rational, as the population structure is youthful (Manyeneng, Khulumani, Larson, & Way, 1985; Togonu-Bickersteth & Akinnawo, 1989). Many developing countries have similarly succeeded in reducing the incidence of tropical diseases and infant and child mortality (Hill & Pebley, 1989).

In Botswana nurses comprise the largest number of health care personnel and are deployed to the rural areas where most elderly people live. Given their central role in the health care system, nurses need to rise to the challenge of becoming advocates of the elderly and to realize that the issues and demands associated with the aging population cannot be solved at the micro level. An awareness of the context of aged care is necessary in order to understand how related issues interact and impinge on aged care, and the work of nurses.

As Blumer (1990) said, "the task of the officials who have to deal with social change incident to early industrialization should be getting the information necessary to the formulation of realistic social policies" (p. 166). For the nurse researcher, there is an obligation to make this information available so that nursing interventions and health policies can be based on appropriate data. Social policy plays an important strategic role in influencing the process of social change under industrialization and other non-industrial forces by supplying direction to such changes and exercising control and guidance over them (Blumer, 1990).

Country Background

In order to understand the context in which this study takes place, it is important to discuss the country background as the study of family caregiving of the elderly is embedded in it. The Republic of Botswana occupies an area of 570,000 square kilometers, approximately the size of France or the state of Texas in the United States. It is landlocked and shares borders with Namibia to the west, South Africa to the south, Zimbabwe to the east, and Zambia and Angola to the north. Botswana attained its independence in 1966 after having been a British protectorate for about a century.

The word Botswana pertains to the country while Batswana refers to the citizens in plural or Motswana in the singular. Batswana also specifically refers to the people who belong to the Tswana ethnic group. The word Setswana refers to both the language of Batswana as well as to the culture. Tswana refers to the ethnic group to which all Batswana belong, irrespective of the country of origin or residency (Seboni, 1993). Pula refers to the currency of Botswana.

Most of Botswana's citizens are members of Setswana speaking tribes or clans, composed of eight major tribes. There are other groups including the BaKalaka in the northeast, Basarwa (!Kuhn, also sometimes called the Bushmen) and other semi-nomadic groups in the more remote areas, and BaHerero in the west. The other groups include people of Asiatic and European origin (less than 2%), and those from neighboring African countries (Lesetedi, Mompati, Khulumani, Lesetedi, & Rutenberg, 1989). However, the official languages of the country and the medium of instruction are Setswana and English.

Family Background

An historical overview of the structure of the traditional extended family and living arrangements in Botswana is necessary in order to understand the plight of the aged people and how the care of the aged by families in Botswana has been altered.

The traditional family in Botswana typically comprises a man, his wife or wives, and their unmarried children, their own or adopted, as well as any other relatives or unrelated dependents who may be attached to them. Quite often the family may also contain unmarried dependents such as the husband's younger brothers or sisters, or unmarried dependents such as sons, brothers, and possibly even daughters or sisters with their respective spouses and children. There may sometimes be servants or other unrelated strangers living within the household (Schapera, 1955).

One or more families of three or four generations make up a household or the group of people living in the same collection of huts (Schapera, 1955). Urban dwellings have fewer rooms and may not be able to accommodate as many people as rural households. In the rural area, the elderly female who is usually unmarried, widowed, or divorced, may share a hut with young children. Therefore, the family group is fundamentally a group of families closely united by marriage or blood, with members living side by side in adjacent homesteads (Schapera, 1955).

Living Arrangements

A unique feature among the Batswana is that, by tradition, most own three homes (Campbell, 1980; Coclough & McCarthy, 1980). Most Batswana possess a home in the central village, another one on the agricultural lands, which is usually fairly close, and a third one located at the cattle post which is likely to be far from either one of the other two homes. This system came into being because of colonial tribal law which prohibited the rearing of cattle (with the exception of trek-oxen) in agricultural lands except after the completion of harvesting (Campbell, 1980). Rearing of cattle near the central village and growing of crops near a cattle post was forbidden. Women spent the sowing and growing season at the agricultural lands whilst servants and male children herded and grazed cattle at the cattle posts. Men spent a portion of their time at each of the three seasonal homes. Agricultural lands were deserted after the harvest and most people returned to their homes in the central village. This practice is still in operation (Otaala, 1982).

This policy led to a split of the family during the course of the year (Otaala, 1982). The effects of the family being split over two or three homes has only been reported for children, who were found to care for themselves in the absence of adults as they had to remain in the central homes in order to go to school. The effect of this system has not been reported for the elderly. However, it clearly must pose a challenge to families who have the responsibility of caring for the elderly.

Botswana Health Care Delivery System

The government health system primarily falls under two ministries. The Ministry of Health is responsible for the formulation of the overall health policies, for the employment of hospital, health center and district health team staff, as well as the training of all categories of health staff. The Ministry of Local Government and Lands (MLGL) manages all the clinics and peripheral health services. MLGL also employs all the staff who are employed in the settings for which they are responsible.

Primary Health Care

The concept of primary health care is the philosophy upon which Botswana health care is based. The system of health care delivery is tiered and pyramidal, based on the population of the catchment area. The health posts in the rural areas are the foundation. The next level is the health clinics, which serve a population of 5,000 to 10,000 and offer more care. The next level is the primary hospital that offers more complex care and is found in large villages and towns. At the apex are the two referral hospitals, one in the south and the other in the north in the country's largest city and town respectively.

Hospitals and clinics are operated by mines, missions, the government, and the public sector. Informal health care is provided by traditional health practitioners for a fee. Government hospitals offer health care for free or nearly so. Health services are free for children, and two pula ($.66) for adults, although in theory no one is turned away for lack of funds. The health care services offer comprehensive care with an emphasis on certain age groups.

The community health workers, known as Family Welfare Educators, are ideally local people who were selected by their own community, trained for four months, and who remain in that community. They work under the supervision of the registered nurse. FWEs spend minimal time in the clinic and most of their time in the community doing home visits and other community related jobs. Consequently, they are in touch with the rest of the population within the catchment area of the clinic. In those settings in which they also belong to the community in which they work, they tend to know most people in their communities.

The clinics also employ Community Health Nurses, who, by virtue of their preparation, are supposed to do home visits. However, they are not always able to do so due to the overwhelming workload they face at the clinics (Anderson, 1989; Personal Communication). Therefore, the health personnel who are most in touch with the rest of the community at grassroots level are the FWEs.

Government run outreach programmes are targeted at the remote areas where there are no clinics. These consist of mobile clinics which are operated by the clinic nurses on a monthly basis. Basic services like immunization, family planning services and other curative services are rendered. At the time of data collection, there were no home health services operated by the Ministry of Health, but plans were in place to start home-based care for AIDS patients. Some non-governmental hospice organization was operating a home based care program for the terminally ill patients. Therefore, following discharge from the hospital, patients had to go to the nearest clinics in their communities for follow-up care.

In the absence of outreach programs within the main villages, clients have to go to the clinic for consultation or to obtain further medication for chronic conditions like diabetes and hypertension. However, in some villages, depending on the workload of the nurses, some nurses were able to do home visits. In the cities, ambulance services were provided for those who could afford to pay for them. However, in the rural areas there were no ambulance services, and the infra structure was not as developed as in the city and towns. To a large extent, the availability of public transportation depended on the extent to which the roads had been developed. As a result, some rural places had no public transportation and people in those areas hired other people's vehicles for transportation to the nearest town.

Although Botswana was one of the poorest countries in the world at independence in 1966, it's economy has since been transformed into one of the richest in Africa. Yet, there is growing concern over what seems to be persistent poverty and increasing inequality in the distribution of income and wealth, both between and within the rural and urban areas (Hope, 1997). More than half of the rural population, and a considerable proportion of the urban population, live below the poverty line. Given that the majority of the population lives in the rural areas, it is estimated that 50% of the population is below the poverty line (Jefferis, 1991).

In Gaborone, the capital city where some of the data was collected, 21% of the families lived below the poverty line compared to 55% nationally. In urban and rural areas, 30% and 64% of families respectively, live below the poverty line (Central Statistics Office, 1991). While these statistics are disturbing, the government of Botswana must be commended for its early recognition of the poverty problem and its manifestations, as well as some of its early efforts to mitigate its impact (Hope, 1997). In November, 1996, at a national workshop on the *Quality of Life in Botswana* held in the capital city of Gaborone, the issue of poverty and ways of managing the situation were discussed at length.

Purpose of the Study

The purpose of this study is to identify and describe the experiences of family caregivers in Botswana. An understanding of the day-to-day experiences of Batswana families with caregiving responsibilities for elderly people will provide baseline information on the process of family caregiving in Botswana. It is hoped that the conceptualization of caregiving will help policy makers and nurses to establish culturally appropriate policies and programs based on expressed needs of community based caregivers, so that nurses' actions have the greatest pay off.

The specific aims of the study are to: (1) identify who the family caregivers of the elderly are; (2) understand what the experiences of Batswana family caregivers of the elderly are; (3) describe the Batswana family caregivers' perceptions and appraisals of caregiving of the elderly; (4) describe changes in ways of dealing with caregiving over time; and (5) identify caregivers' sources of help during the caregiving process.

The next chapter discusses the literature review. Chapter Three discusses the methodology and study design. Chapter Four discusses the findings of the study. Chapter Five summarizes the findings and implications of the study for research, practice and policy.

CHAPTER 2

LITERATURE REVIEW

As there are no studies on *family caregiving* in Botswana and other African countries, this review and critique will focus on literature related to the *situation of the elderly* in Botswana and other African countries. American literature on family caregiving will be reviewed for comparative purposes.

In order to provide context for the proposed research in Botswana, the following review of caregiving research has been organized to reflect the separate and parallel development of knowledge pertaining to caregiving in developing countries and developed countries. The first two sections depict the different stages of knowledge development of caregiving in these two distinctive but not homogeneous worlds.

Of these, the first are mostly descriptive and seek to explain the state of the elderly in Africa within the last two decades in light of social changes that most African countries are undergoing. The primary focus will be on Botswana. The second section focuses on research in western countries and briefly discusses characteristics of caregivers and care recipients, the process of caregiving, and the effects of caregiving; it also reviews instruments which have been used to measure the effects of caregiving in western countries. The final section identifies gaps in the literature in both worlds.

Situation of the Elderly in Developing Countries

Whereas in western countries the focus of literature has mainly been on caregivers of the demented elderly and elderly people with other specific diseases, in developing countries the focus has been less disease oriented, due to a lack of statistics pertaining to diseases and illnesses of the elderly, and more “family support” oriented.

Guillette (1990) examined the social position of the Batswana rural based aged people as perceived by urbanites and villagers in an ethnographic study. Data were collected from a random sample of 23 females and 27 males (N=57) over two months using a structured interview and participant observation. The sample was drawn from the capital city (N=23) and four villages (N=34). Views of the general public and of the aged individuals were solicited regarding the old and new customs. All but seven interviews were conducted in English. An interpreter assisted with the non-English speakers.

The findings revealed that grandparenting was an important role for most of the aged. Grandchildren were the only relatives of some rural elderly respondents, although some had additional relatives within the vicinity. Visits from the grandchildrens' parents were reported as rare, as were donations of money. Child care was provided by the elderly for employed and migrant daughters. Child care was viewed by the aged as a way of maintaining the traditionally interdependent extended family relationships.

Aged people uninvolved in grandparenting sought employment in the village, as it was considered prestigious to be able to continue to earn an income. Unfortunately, well-paying jobs, although scarce in the rural areas, required skills and education which the aged often lacked. Consequently, many of the positions involved hard physical labor that took its toll on the aged. Homebound elderly were economically dependent, and some of them spent the day alone.

Expressed needs were more for social services than for money, e.g., home repairs, transportation to community gatherings, etc. However, relatives of the elderly placed emphasis on the economic dependency of the old people.

The author recommended the institution of community programs that would allow the active old to remain in economically productive roles so as to relieve the family members of the hardships associated with fulfilling the valued family obligations. Educational programs that would enhance the relationship between the homebound elderly and the family were also recommended.

There was no mention of how the data were analyzed. The study was more descriptive than ethnographic in nature. The sample size was too small to allow generalizability of the findings. The researcher seemed to have misunderstood certain colloquial expressions in his translation of the data.

In a comparative study, Draper & Keith (1992) examined community norms about aging as well as variability among people in their perceptions of the life course, and cultural contexts of caregiving for the elderly among the !Kung of western Botswana and the Americans in a suburb of Swarthmore, in Pennsylvania. Data were collected from adults over the age of 18 (N=105) belonging to the !Kung communities in 30 different villages in western Botswana. In Swarthmore, a probability sample of residents over the age 18 was selected using a cluster strategy (N=205). Of this sample, 50 people were aged 65 and over. Methods of data collection included field observations, life histories, and a standardized interview format.

American participants derived a sense of personhood from financial and residential autonomy. The first source of care was a spouse, and widows were the most vulnerable to institutionalization because of present or future needs for care. Old people relocated to be nearer to their children, or to specialized housing, which frequently cost them ties to their community.

Over 80% of !Kung 60 years and over were already living close to at least one child. Those who had no surviving children had already established reciprocal ties and near-by residence with in-laws, grandchildren or other collateral kin. Elders did not retire, relocate, or enter age-graded elder care institutions; indeed they had nowhere to go. Although participants from both cultures mourned the loss of the capacity to take care of themselves, the !Kung did not identify living alone or being separate from others as a value. The American participants, on the other hand, valued independence and the ability to live alone.

The !Kung regretted the loss of action and the kinesthetic satisfactions of vigor and strength, understandably so given the hardships of having to fetch water from a well or firewood from as far away as one to three kilometers. Furthermore, the basic mode of transportation was by foot and, consequently, visiting other villages was harder for the elderly than for the young.

Participants from both cultures were asked to rate their own health. In Botswana, the authors used a 5-point scale so people could rate themselves using their five fingers. Whereas in Swarthmore over 50% of old people rated their health as good or excellent, among the !Kung about 50% of old people rated their health as poor or very bad. Only 25% of the old !Kung men and women rated their health as good.

While these findings may reflect the development of the health systems in the two cultures, one is inclined to think that they may also reflect measurement issues in different cultures. The Likert scale has been found to cause problems in non-English speaking populations (Flaskerud, 1988; Kay & Portillo, 1989), although there has been no specific documentation on the ability of the Batswana to respond to Likert scales appropriately.

Care of the elderly person was gradually assumed by one of the people he or she was already living with, most often family members. However, this was sometimes problematic, as when family members had to travel long distances to graze cattle and could not take the frail elderly person with them. In the U.S., the family also assisted the elderly people in their own homes. Paid help was often used, and some elderly relocated to live with their children. In some instances, it was necessary to institutionalize the elderly. Exemplars for analytic points were presented and they supported the analysis. Triangulation of time and data sources were used, establishing rigor in the study.

Ingstadt, Bruun, Sandberg, & Tlou (1992) conducted an exploratory descriptive study to examine the role of Batswana rural elderly women as caregivers and recipients of care respectively. Data were obtained by participant observation, medical examinations, and semi-structured interviews. The preliminary findings from this on-going study are based on a sample of 38 elderly women.

The health status of all persons aged 60 and above in a rural village (n=450) was assessed through medical examinations. A semi-structured questionnaire was also used to elicit data regarding their medical beliefs and practices, and social aspects of their life situations. Fifth grade students from the same village were asked to make drawings depicting the lives of elderly men and women in the village. An essay contest was also administered to seventh and ninth grade students, who were asked to write about their own perceptions of the situation of elderly people in their village, and how they envisioned their own lives as elderly in the future.

The present analysis was based on a sample of 38 women; 23 were widows, nine were married and lived with their husbands, four were divorced, and two had never been married. Of the 23 widowed elderly, two lived alone, 11 lived in households where they were heads, and six lived in households headed by daughters. The ages of the participants ranged from 60-100, and most of them were still active and functioning well. Only 11 exhibited deficient mental capacities. About 18 were satisfied with the care they obtained from family members, 6 were partly satisfied, and almost a third were very dissatisfied.

Elderly roles included grandparenting (n=15), and supervision of activities of adult granddaughters. Eight were care-recipients, and they reported their health as poor; the rest rated their health as fairly good (n=2) and good (n=5) respectively. These latter findings are in contrast with the findings of Draper & Keith (1992).

The findings of the students' essays depicted the lives of the elderly as difficult (65%) due to their scarcity of resources and lack of support by their children. Only 11%

thought the elderly had a good life, and 24% described both positive and negative aspects of elderly lives. The results of the drawings of the students were not reported.

Although three studies were reported, the authors did not state how they analyzed their data. The results reflected more of the social situation of old people than the caregiving aspect, yet the latter was the purpose of the study. Multiple data sources strengthened the reliability of this study.

Critical Summary of Literature on Family Support of the Elderly in African Countries

Apt (1993) presented data on social and economic conditions influencing the care of the elderly in Ghana, West Africa. The data were based on research findings, personal observations, and field studies of social work students from case studies of HelpAge Ghana's "Adopt a Granny Program." The records of the 218 elderly (50-65 years) destitute people who were admitted to the infirmary in 1971 were reviewed.

Most of these destitute people were immigrants from neighboring African countries who had lived in Ghana for many years. However, 15 of these were indigenous Ghanaians from a poorer part of the country. Although some had some interested kin, these known relatives were too poor to take care of their elderly destitute kin. Most of the immigrant elderly were completely out of contact with existing kin, in either Ghana or in another African country. However, some of them had no known kin available. Most referrals to the infirmary were from hospitals and, consequently, most required regular medical supervision on admission.

There seemed to be an abandonment of elderly people, particularly post hospital discharge, in Ghana's capital Accra, and other larger towns. Some welfare programs had been established in various parts of Accra, including a day care center. Programs were available for the homeless elderly and even those who lived with their families. Although in the midst of family relations, some elderly lacked care and companionship, and these organizations helped them to socialize.

Initially, family care had occurred in three generational households. Changes in school attendance, migration, and employment, as well as economic hardships had curtailed the ability of the extended family to meet its obligations and had shifted this responsibility to a nuclear family. The data sources illustrated the role of the family, especially grandchildren, in the care of the elderly. Grandchildren emerged as a crucial means by which adult children take care of their parents. The author concluded by noting that things would only worsen for future elderly cohorts unless intervention programs were instituted.

Although the study is descriptive, the author did not clearly distinguish between the findings of the study that he was reporting on and the literature review. The four case studies provided exemplars of analytic points, and to some extent, supported the analysis.

In an exploratory descriptive study of the elderly in six rural villages in Northeast Thailand, caregiving to the elderly was examined (Caffrey, 1992). Data were collected from 89 households with elderly aged 65 and over. A subgroup of 39 caregivers was selected from the 89 households. All but three of the 39 caregivers were females with an average age of 40, and a range of 13-74. In Thai tradition, the youngest daughter typically assumes the caregiving role. Therefore, most caregivers were daughters, (53.3%), while 13% were daughters-in-law, 15% were grandchildren, and one was a son. The rest were unaccounted for in terms of their relationships.

The findings of the health assessment revealed that 95% of the elders were able to perform most of the activities of daily living unassisted. Some described their health as fair to poor (75%). Pain, especially in the joints, was the most common problem. Four levels of caregiving were identified. Level one involved taking on the head of household responsibilities when elderly parents consciously turned over these responsibilities to the identified caregiver. The average age for turning over responsibility was 67 years, but the elderly continued to contribute to the household through child care, cooking and cleaning, and religious activities. Level II occurred when the elders ceased assisting with common household chores and religious activities, usually after age 75.

Level III occurred when the elder was ill and the caregiver had to take on additional responsibilities associated with the illness. This stage could happen at any age and its duration could be temporary (allowing a return to one of the earlier stages), or until the elder died. Level IV activities included arranging an appropriate funeral and making offerings on behalf of the deceased, particularly those who died without merit and who according to traditional beliefs, had to remain on the temple grounds as ghosts.

Methods of data collection were not clearly spelled out, nor was the data analysis. Chi square and anova were the primary statistical analysis tests used to test for significant differences in family care of the elderly, but the results were not reported. However, the author provided important information regarding conceptualization of caregiving in Thailand.

Cattell (1990) studied aging and old age among the Samia of western Kenya in an ethnographic study. Data were obtained by participant observation, informal and structured interviews, and a survey of about 10% of those aged 50 and above (n=416) in four sub-locations of Samia. In the survey, 78% of the women and 70% of the men lived in a family compound with three generations, comprising mostly daughters-in law and grandchildren. Some were childless (6% of the women and 4% of the men), and a few had only one living child (6% of the women, 3% of the men).

Samia ideologies incorporated intergenerational reciprocity and familial interdependence throughout the life course. Old age was also a time to be rewarded with gifts, money and services, especially by children. The ability to continue working was important to Samia's self-esteem as being unable to work met the cultural definition of old age. Successful old age was associated with being able to be provided for by one's children. Both sons and daughters were expected to care for their parents, although the onus of caring for the elderly and often widowed mothers particularly fell on the last born son. However, in reality much of the sons' obligation fell on extended family members, particularly daughters-in-law and grandchildren.

Three case studies were selected to portray the fit between Samia ideologies and reality in a rapidly changing society. These studies were considered representative of the difficulties which were experienced by some, and the family support received by some.

The survey comprised (n=416) 200 women and 216 men. Most (89%) admitted to receiving some assistance from children and often from grandchildren (53%) as well as other kin. Assistance was given in the form of gifts, work and money. Types of support from family members varied according to gender. Women received more assistance from their children than men in all instances, except work from sons, where men obtained more, and money from daughters, where there was very little difference.

Religious groups were mentioned as non-family sources of help by 42 people. In return the elderly provided child care, and help to others (29% of the women and 41% of men), and were repositories of knowledge. However, as they become older and more frail, their ability to reciprocate diminished.

Being childless or without a son presented more difficulties for women than men, because men usually had at least one wife to take care of them. Approximately 20% of the sample were childless, or with children of only one sex. Furthermore, 56% of the sample were widowed, 46% of the women in the sample were in their 60s, and nearly all those aged 70 and above were women. The mother-daughter bond was very strong, although daughters changed residence after they were married.

Limitations of the study were that few survey interviews were conducted in privacy, and consequently obtaining data was problematic. Some participants may have denied obtaining assistance as a way of indicating dissatisfaction with the level of support. Some concealed resources to protect themselves from a neighbor's jealousy, or to solicit assistance from an outsider such as the researcher. The triangulation of methods and data sources strengthened the validity and reliability of this study.

Regrettably, the literal translation of concepts without the retention of the equivalent meaning of the concepts, tends to make the text meaningless and not representative of what the respondents actually meant. Often in African studies, the meaning could be understood if literally translated back to an African language. However, as the audience of the professional journals is not predominantly African, but a community of international professional scholars, it is important that concepts be translated in ways which retain their conceptual meaning. An example is the category "sit and eat" used in studies of the elderly in Kenya. Traditionally, the elderly are expected to be able to just "sit and eat" if well supported by their families in old age. Thus, this statement is meant to portray a state of self-actualization on the part of those elderly who could benefit from family remittances. This meaning, while retained if literally translated into another African language, is lost when translated into English.

Peil, Bamisaiye, & Ekpenyong (1989) examined the help which elderly Nigerians obtained in the form of services from family, relatives and non-relatives, and the effect of their age, sex, location (urban/rural), and state of health on the provision of these services. Surveys were carried out in 1984 and 1985 in three provincial cities in southern Nigeria, Abeokuta, Ijebu Ode and Port Harcourt, as well as in six to eight of the villages surrounding each of these cities.

A total of 668 men and 336 women over the age of sixty were interviewed. Sixty was used because it is the official age for retirement from employment in Nigeria. Data pertaining to occupation, and migration history, living conditions, health and support received from children, siblings, relatives and neighbors were collected.

A quota sample of two men to every woman, although unrepresentative of the population, was used because experience had shown that women were far more homogeneous in their experience (education, migration, occupation and marriage) and attitudes than men. The authors contended that it took a larger sample of men to study the range of responses in the population. Random sampling was not done due to lack of both funds and time. Two people per household were interviewed.

The findings indicated that children were by far the most important source of services, followed by grandchildren. Care for the elderly was generally seen as a family responsibility. Failure to provide for parents when one could do so was not condoned. Family members who remained at home helped by providing services and those who had migrated sent remittances. State welfare provision was limited to the few whose wage employment provided a pension.

Females comprised the majority of the rural elderly. There seemed to be as many old men as old women in West African towns due to migration. Both old men and women moved to cities temporarily for access to modern medicine, but this was usually only a visit. Old men usually remained at home permanently as they were taken care of by their younger wives (due to high levels of polygamy and remarriage).

In patrilineal societies, elderly women sought permanent residence with a son. This presented its own problems, e.g., conflicts with a daughter-in-law, crowded urban housing. About 20% of Abeokuta urban and Port Harcourt women lived alone. Women over 85 were most likely to live alone.

Four domestic tasks which required assistance were cooking, laundry, marketing, and fetching water. Women were more likely than men to carry out domestic tasks. Relatives assisted with domestic tasks, especially marketing and fetching water as these required mobility.

In a survey, Togonu-Bickersteth (1989) examined the caregiving behaviors of adult children towards their parents in Nigeria. A purposive sample (N=100) was obtained from among salaried workers in a university and from the staff of two secondary schools in two states. The sample comprised 54 male and 46 females. Their mean age was 35.5 and ranged from 25-55 years. Eighty four percent of the sample was married, and 76% had children. In addition, 68% had financial obligation for other relatives. The mean age of the mothers of the respondents was 62.6. Only 17% were living in the same household as the respondent, while 13% lived elsewhere in the same town. The majority of mothers (70%) lived in other towns or villages. None of the mothers were living alone.

Females expended a greater percentage of their income (21.3%) for parent support than males (15.8%) and, for both sexes, married people spent a greater proportion than single people. The greater the adult's take home pay, the lower the percentage of income spent on parental care. Those whose mothers had a reasonable source of income reported spending less of their income on the parent maintenance. When asked to report the major problems pertaining to caring for the mother, 70% reported their limited financial resources as a major constraint. Therefore, although the family members continued to take care of their parents, they did so at a high financial and emotional cost.

The sample size was small and unrepresentative. The authors admit that they did not use any inferential statistics due to the small sample size. The findings were based on self report and, as the authors pointed out, socially-approved responses may have been given, masking the neglect of aged parents.

In a survey in Zimbabwe, Adamchack, Wilson, Nyaguru & Hampson (1991) examined the elderly support and intergenerational transfer by gender, marital status and place of residence for 150 elderly persons aged 55 and above. A clustered purposive sample was obtained from communal (N=75) and commercial (N=27) farms (rural), and urban areas (N=48). One elderly person in each household was interviewed. Age 60 was considered the social definition of old age because formal sector mandatory retirement age is 60. The mean age was 69.1 years. Forty one per cent of the respondents were male, and 59% were females; 48% were married and 52% were unmarried (47% were widowed and 5% divorced, separated or never married).

The mean income per month for the total sample was Z$623 (US$77) in September 1988, which was approximately one third of the formal sector minimum wage. The most frequently reported source of income was children, as 45.3% of the respondents received money from this source. Only 3.4% of the sample received a pension as very few Africans participated in pensions prior to independence. Other sources of income were agricultural products and receiving rent money for leased property.

Commercial farm workers were employed for as long as they could work. A significant proportion of commercial farm workers in Zimbabwe were from neighboring countries and may have lacked an extended family system and access to communal land.

The authors questioned their ability to economically sustain themselves after they stopped working.

Men received 2.6 times the income and cash received by women. Married women received three times the amount of income received by unmarried women, as some unmarried women did not have children (13.3%). The largest source of income for men was salary. For married women, the largest source was from spouses. Elderly women, particularly unmarried ones, were the most vulnerable due to their low income and little cash generated; they relied on agricultural production and their children for more than 56% of their income and cash.

Clearly children supported the elderly considerably. The authors questioned how long traditional family support could sustain the elderly, and how the Autoimmune Deficiency Syndrome (AIDS) epidemic would in time affect the elderly in Africa, as it was already taking its toll on the young people who were making monetary donations to the elderly. The authors also recommended periodic surveys of elderly support and intergenerational transfers in the countries of sub-Saharan Africa.

The sample size was small and unrepresentative, and elderly support was only limited to well elderly. More research needs to be done with the elderly who required physical care, as well as elderly who are immigrants from other African countries.

To summarize this section, studies on the elderly in Botswana, Kenya, Ghana, Nigeria, Thailand and Zimbabwe were reviewed. All the studies were descriptive. In all the studies, the family was depicted as an important source of support. The literature seems to indicate that support is conceptualized as economic (Guillette, 1990;

Adamchack, Wilson, Nyaguru & Hampson, 1991), yet there seems to be need for other social services which are not necessarily economic (Apt, 1993; Guillette, 1990). Women were primary caregivers with support from other family members (Apt, 1993; Caffrey, 1992; Ingstad, Bruun, Sandberg, & Tlou, 1991). However, more research is required to clearly depict the characteristics of the people giving family support. Although successful old age was associated with being able to be provided for by one's children, the ability to continue working was important to Batswana and Kenyan's self-esteem since being unable to work was equated with the onset of old age (Cattell, 1990; Guillette, 1990). Grandparenting featured as an important contribution of non-working elderly (Apt, 1993; Guillette, 1990; Ingstad, Bruun, Sandberg, & Tlou, 1991).

Validity was threatened by lack of power-analysis in all the reviewed quantitative studies. Although some researchers used large sample sizes (Peil, Bamisaiye, & Ekpenyong, 1989), they still failed to establish the power-analysis. Lack of randomization and use of convenient samples (Peil, Bamisaiye, & Ekpenyong, 1989) was observed. This poses a threat to generalization of findings.

There seem to be many definitions of the elderly. In some countries, the definition was mathematically modeled to reflect the life expectancy of developing countries, bringing it down to as low as 55 (Adamchack, Wilson, Nyaguru & Hampson,1991). Furthermore, some of the elderly in developing countries did not know their exact ages (Adamchack, Wilson, Nyaguru & Hampson, 1991; Cattell, 1990; & Ingstad, Bruun, Sandberg & Tlou, 1992), and in these instances, age was usually estimated according to the major events which occurred at the time of their birth, for example, World War I, or by the age of their eldest child. Consequently the task of generalizing or comparing research findings in cross-national studies may be difficult.

There were inherent problems with the definition, analysis and interpretation of qualitative studies. What were termed qualitative studies often read like descriptive studies (Cattell, 1990; Guillette, 1990). The caregiving literature on these countries is still in its infancy. Research on the impacts of social change on the elderly has gone through a predictable pattern common to new research in the social sciences. The studies to date, although methodologically unsophisticated, do provide some base line information about the needs and status of the elderly in developing countries, and that is an important point from which to begin. The next section discusses caregiving literature in the U.S.

Caregiving in the U.S.

The provision of care to dependent family members in the U.S., as in other parts of the world, has always been done by families. Historically there was little public support for family care of the elderly in the home (Biegels, Sales & Schulz 1991). The large national scale studies brought national attention to caregiving as a public policy. In their classical study, Shanas & Streib (1968) refuted the belief that older people were abandoned by their families and socially isolated.

Caregiving research in western countries has developed along two major lines. The first has focused on the caregiving process itself, with major emphasis on the effects of caregiving on the caregivers, while the second stream of research has focused on interventions to address patient and caregiver needs (Biegel & Blum, 1990).

Characteristics of the Caregiver

The common caregiver situation in the western world involves a woman, often aged 55 or over, as the primary provider of services, supported primarily by other family members and, to a lesser extent, by friends and neighbors (Gallagher, 1985; Stone, Cafferata, & Sangl 1987). Usually, one family member who occupies the same household as the care recipient assumes the role of primary caregiver, while other family members take on a secondary role (Soldo & Myllyluoma, 1983; Stone, Cafferata, & Sangl, 1987). Whereas elderly women are cared for by children, usually daughters or daughters-in-law, elderly men are cared for by spouses as a consequence of the female advantage of longevity. In the absence of both spouse and children, siblings, grandchildren, nieces, and nephews take on the role of caregiving (Brody, 1981; Cicerelli, 1983; Gwyther & George, 1986; Soldo & Myllyluoma, 1983; Stone, Cafferata, & Sangl, 1987).

Some studies have found that caregiving affects older caregivers (most of whom are spouses) more adversely than younger caregivers (Biegel, Sales & Schulz, 1991; Cantor, 1983; Clipp & George, 1993; Fengler & Goodrich, 1979; George & Gwyther, 1986). Assumption of the caregiving role is dictated by demographic imperatives (e.g., only child or only female child), geographic obligations of reciprocity, and situational factors (e.g., child with the least amount of competing commitments) (Given & Given, 1991).

Characteristics of the Care Recipient

In the caregiving literature, patients are characterized according to gender, relationship to the caregiver, their cognitive status and, less frequently, according to the diagnoses health care providers assign to them (Stoller & Earl, 1983). More information and description is needed about characteristics of the care recipient and how they impact the overall caregiving process (Given & Given, 1991). This information is also unavailable in Botswana and other developing countries. There is, furthermore, a controversy in the literature pertaining to whether the physical or mental impairment of the care recipient makes the caregiving more difficult for the caregiver (Wright, Clipp & George, 1993).

The Processes of Caring for the Elderly in the Home

In assessing the process of caregiving researchers must consider the natural process of the caregiving trajectory and the point in that course at which the assessment is made (Given & Given, 1991). Although length of time spent in the caregiving role is not a clear determinant for negative outcomes, caregiving literature which describes differences in such processes across a longitudinal care trajectory is minimal.

In a grounded theory approach, Bowers (1987) conceptualized the organization of caregiving in terms of the meaning or purpose attributed to an activity by the caregiver. Categories of caregiving included anticipatory, preventive, supervisory, instrumental, and protective caregiving. Only instrumental caregiving included the hands-on caregiving tasks. The rest, although unobservable behaviors, are processes crucial to intergenerational caregiving and to an understanding of the experience of caregiving.

Wilson (1989a, 1989b), in a grounded theory study, identified caregivers' trajectory of coping with negative choices and the social processes of surviving on the brink. The conceptualizations by Bowers (1987) and Wilson (1989) are important perspectives that broaden the scope of caregiving beyond a set of tasks. Lindberg (1993) and Pearlin (1992) also identified caregiving as a career. Cattell (1990) identified caregiving as a process that continued beyond the death of the elderly in Kenya. Although a few studies are available on processes of caregiving, more should be carried out.

Caregivers' Reactions to the Caregiving Process

Early caregiver research studies focused on the roles, needs, and burdens of family caregivers. Then measures were developed to quantify the concept of burden itself. Various burden scales were developed in an attempt to quantify the concept of burden on both an individual and global level. A parallel stream to research on the effects of caregiving on the caregiver focused on the interventions or outcomes of interventions designed to ameliorate the impact of caregiver burden (Biegel, Sales & Schulz, 1991).

Instruments Which Measure Caregiving Effects.

According to Deimling (1994), caregiving effects can be categorized into three groups: global physical health, mental health effects, and well-being experienced by caregivers. The latter can be positive (caregiver satisfaction) or negative (caregiver burden). There is a great variability across studies concerning how the caregiving effects have been conceptualized and measured (Raveis, Siegel & Sudit, 1990).

Various instruments were developed to measure caregiving effects during the period 1982-1991. These will be briefly reviewed because they provide sufficient depth of information to permit discussion of their applicability to Botswana.

One of the classic measures of burden is the Burden Scale developed by Zarit and his associates (Zarit, Reever, & Bach-Peterson, 1980; Zarit, Todd, & Zarit, 1986; Zarit & Zarit, 1982). This scale has been widely used (Pratt, Schmall, Wright, & Cleland, 1985; Young & Kahana, 1989), and asks caregivers to indicate the extent to which they perceive their emotional or physical health, social life, financial status, and the relationship between the caregiver and care recipient have been adversely affected by caring for a family member with senile dementia. The Burden interview was designed to be used as a single total score without subdimensions, and the total score was found to correlate weakly with caregiver stressors, such as the impairment of the care recipient (Deimling, 1994).

Cantor (1983), using data drawn from a larger study, examined how the provision of care to frail elderly affected the lives of the caregivers (n=148). Included in the inventory administered were seven items to measure the quality of caregiver/care receiver relationships and the extent to which the caregiver experienced emotional strain.

Robinson (1983) developed the 13 item Caregiver Strain Index (CSI), with a view that the presence of a problem is evidence of strain. Although unidimensional, the CSI reflects common stressors associated with caring for an older relative post discharge, following acute hospitalization for hip surgery or heart disease. This may limit its usefulness in studies with caregivers of care recipients with different types of conditions

(Vitaliano & Young, 1991). Because the content validity of burden measures designed for one type of caregiver or care recipient is questionable in another type of population, it can, therefore, not be applicable to all populations (Vitaliano & Young, 1991).

Poulshock and Deimling advocated that burden should be viewed as a multidimensional concept in which specific burdens are linked to specific types of impairment. Montgomery, Gonyea, & Hooyman (1985) developed one of the first measures to operationalize caregiver burden which distinguished between objective and subjective burden. They also reported that while subjective and objective burden were correlated (r=.34), the two types of burden differentially correlated with specific caregiving tasks, especially the confining ones.

Although not developed based on empirically derived factor structures, these measures are based on conceptualizations that are prominent in the caregiving literature (Deimling, 1994). However, the validity of using an inventory developed on demented elderly for the study of community dwelling frail elderly has not been addressed (Vitaliano & Young, 1991).

Novak & Guest (1989) developed the Caregiver Burden Inventory (CBI), a multidimensional measure of caregiver burden. Items were derived from the experiences of caregivers of individuals with Alzheimer's Disease and review of burden literature. It can be utilized by practitioners to create a caregiver burden profile and make clinical decisions pertaining to interventions.

The Caregiver Hassles Scale (CHS) was developed to measure the day-to-day demands of caregiving (Kinney & Stephens, 1989). The indicator represents several categories of hassles; those associated with assistance with basic and instrumental activities of daily living, care recipient cognitive status and behavior, and caregiver support network. Although the CHS complements more global measures of burden, it does not assess subjective burden in relation to the items, because the presence of a hassle does not necessarily imply burden (Vitaliano & Young, 1991).

Lawton, Kleban, Moss, Rovine and Glicksman (1989) have developed a tool with a subscale that measures caregiving mastery. However, the concept of mastery has not been described adequately, and they have not employed longitudinal studies to determine how caregivers change in their reactions as they master the tasks and demands of caregiving.

Pearlin, Mullan, Semple & Skaff (1990) provided a theoretically based and conceptually sophisticated model for assessing the consequences of caregiving. They provide a model in which the primary stressors emanating from caregiving cause secondary effects entitled role strains and intrapsychic strains, which in turn have an impact on global mental health outcomes. Seven indicators reflect burden or strain.

The Screen for Caregiver Burden (SCB) instrument was developed by Vitaliano, Russo, Young, Becker, & Maiuro (1991). It is designed to measure objective and subjective burden. The primary strength of these two indicators is their conceptual and demonstrated empirical link to major stressors related to caregiving (Deimling, 1994).

Caregiver Satisfaction

Although the literature on caregiving is replete with the adverse effects of caregiving, some studies have focused on the positive aspects of caregiving. Some indicators have also been developed to measure positive aspects. These measures recognize that in spite of the difficulties associated with caregiving, opportunities for the provision of benefits exist, although the positive may not necessarily outweigh the negative aspects (Deimling, 1994).

Lawton, Kleban, Moss, Rovine, and Glicksman (1989) developed a Caregiver Satisfaction Index as part of a multidimensional caregiving appraisal model, which also incorporates measures of caregiver strain. Using the cognitive-phenomenologic stress model (Lazarus & Folkman, 1984) the authors included potentially positive dimensions of the appraisal of caregiving experiences.

Family caregiving research has grown since the inception of the concept burden as unidimensional. There seems to be agreement about the multidimensional nature of the family burden concept. However, there is lack of consensus in the conceptualization and measurement of burden, giving a confusing picture about its correlates and causes (Biegel, Sales, Schultz, 1991). There are certainly many instruments; however, standardization is necessary because the measurement of burden hinges, to a large extent, on how it is conceptualized (Scheene, Tessler & Gamache, 1994).

Study Design and Sampling

Sample sizes for the instruments reviewed above ranged from 29 to 866 subjects. Subjects were selected by convenience sampling which poses a threat to external validity. Generalizability cannot be assumed due to the nonrepresentative sample. Nunnally (1994) suggested that at least 5 times as many subjects as items be recruited for instrument development, or a minimum sample of 300 subjects. Kinney & Stephens

(1989) had 42 items and a sample of 60. Vitaliano, Russo, Young, Becker, & Maiuro (1991) had 25 items and 68 spouse dyads. Zarit, Reever, & Bach-Peterson (1982) had 29 items and 29 subjects.

Instrument Reliability and Validity

Norbeck (1985) suggested that the minimal standards for publishing results of psychometric testing should include at least one type of content validity, internal-consistency reliability, test-retest reliability, and at least one type of criterion-related validity. Waltz, Strickland, and Lenz (1992) identify replicability as a measure of reliability.

Instruments developed for use with Western populations may not be applicable to non-Western populations because certain concepts are not applicable across cultures. According to Flaherty et al. (1988), an establishment of cross-cultural equivalence includes an establishment of the following levels of equivalence: content, semantic, technical, criterion, and conceptual equivalence.

Content has to be culturally relevant. Some of the items used in the western world would be culturally inappropriate because they do not exist in African countries, or if they do, they would exist in a totally different form. For example, instruments designed to measure tasks that a caregiver did in Botswana would need to capture the arduous activities associated with rural life. Other activities like financial management of the care recipient are simply not done because most times the aged person does not have any bills to be paid as they are entirely economically dependent on their family.

Semantic equivalence ensures that the meaning of each item remains, conceptually and idiomatically. Interview questionnaires are usually written in English and must be translated and back translated to ensure semantic equivalence (Ikels, 1991). However, researchers need to be aware of specific cultural and social-structure characteristics that may require item modification that may even be beyond direct translation (Flaherty et al. 1988). In light of this, a qualitative approach to the phenomenon of family support of the elderly will yield concepts that can be later used in the design of quantitative instruments.

More instruments seem to have been used with caregivers of cognitively impaired elderly than any other group. Alzheimer's Disease and the related dementing disorders are thought to be particularly distressing to caregivers by virtue of the behavioral disorders and rapid decrease in functional capacities, necessitating round-the-clock care.

Although there are conflicting findings across studies, three prominent areas of consensus have emerged (Wright, Clipp & George, 1993). The most widely accepted observation is that caring for a cognitively impaired elderly person constitutes stress, and that many caregivers have financial, emotional and physical consequences related to caregiving (Wright, Clipp & George, 1993).

Second, caregiving has more adverse effects for older caregivers than younger caregivers, most of whom are spouses (Biegel, Sales & Schulz, 1991; Clipp & George, 1993). Third, the duration of caregiving is not related to negative caregiver outcomes (Colerick & George, 1990; Biegel, Sales & Schulz, 1991; Malonebeach & Zarit, 1994).

Gaps in the Literature

Research literature pertaining to caregiving of care recipients with various illnesses have developed in isolation (Biegel, Sales & Schulz, 1991). Consequently, there is a knowledge gap pertaining to commonalities and differences in various chronic illnesses that may influence the caregiving experience. However, studies comparing caregivers of various illnesses are beginning to be available in the caregiving literature. George & Clipp (1993) compared the spouse caregivers of cancer and dementia patients, and found that the physical health of dementia caregivers was more compromised than the health of cancer caregivers.

Cattanach & Tebes (1991) compared health consequences for caregiving daughters and daughters-in-law across three types of elderly patients: cognitively impaired (e.g., AD and stroke), functionally impaired (e.g., fractured bones, cancer), and nonimpaired (e.g., controlled diabetes and minor arthritis). Interestingly, the caregivers of the latter group reported the highest occurrence of physical symptoms, and daughters of the cognitively impaired the lowest. Statistically, the different caregiver groups did not differ in the number of physical symptoms reported.

Little is also known about culturally-linked caregiving attitudes and their association with caregiving behavior. Young and Kahana (1995) also add that, although a cultural group may place a greater emphasis on the care of the elderly, circumstances may prevent them from actually applying this to caregiving activities.

The definition of a family caregiver defines how that individual is identified and studied (Barer & Johnson, 1990). There are multiple definitions of the term caregiver

(Malonbeach & Zarit, 1991). These dimensions are based on the elder's level of function, medical diagnosis, style of care, or care needed, family relationships, emotional dependency, and appraisals of the caregiving situation by both the caregiver and the care recipient. The care recipient's perspective has been sparsely reported even when the elders are cognitively intact.

Although there need not be a consensus on the definition of caregiving, Malonebeach & Zarit (1991) propose a model that considers functional status as well as number and duration of caregiving tasks. Some minimal involvement appropriate to the research question should also be specified. This approach would add uniformity to the definition of caregiving and improve generalizability across studies.

Selection bias has been a major issue in caregiver studies. Samples in caregiver studies have been drawn from mailing lists of support groups and formal service providers (Barer & Johnson, 1990; Malonebeach & Zarit 1991), or are recruited through hospitals or social service agencies where the dependent elder is brought for care (George & Gwyther, 1986). Self selected samples may run the risk of underepresenting minority caregivers with lower socio-economic status.

In Africa, although Apt (1993) & Guillette (1990) reported care of the frail elderly by grandchildren, the prevalence or adequacy of this phenomenon has not been investigated. Some grandchildren have been reported to be quite young (Peil, Bamisaiye, & Ekpenyong 1989), and consequently pose a problem for the elderly who have to cook for them. Also, there may be need for further research of grandchildren as caregivers in African countries. Most of the research done in African countries and other developing countries has not been disease focused. There is a dearth of empirical data on living arrangements of the elderly, although there are extant national studies on the elderly.

The last decade has clearly seen an increase in the number of studies on caregiving and family support of the elderly in Africa and Thailand. The caregiving literature in the western world, although quite advanced, still has identified gaps, both in instrumentation and other areas of this phenomenon. Countries in the beginning stages of caregiving research can draw from the available western literature. In the final analysis, data drawn from developing nations must be used to develop instruments for use in those countries.

Research tools which can appraise and assess caregivers' experiences in Botswana need to be developed. The application of research methods and techniques developed in a dominant culture and then transferred to another culture can threaten the validity and generalizability of the research conducted with the second culture (Henderson, Sampselle, Mayes, & Oakley, 1992).

CHAPTER 3

METHODOLOGY AND STUDY DESIGN

The study explored the issue of family caregiving in Botswana. Given the, as yet, undefined nature of this topic, a descriptive exploratory approach using grounded theory methodology was used.

Grounded Theory

The grounded theory approach (GT) to collection and analysis of naturalistic data was originated by Glaser & Strauss (1967). It is a qualitative research method in which users attempt to apply a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon (Corbin & Strauss, 1990). Anselm Strauss was trained at the University of Chicago and was influenced by interactionist sociology and pragmatist philosophy. Barney Glaser came from a very different tradition and was influenced by Paul Lazarsfield and Robert Merton, developers of survey research.

Their method emphasizes a naturalistic approach to inquiry; the importance of theory, grounded in empirical data, to the development of a discipline; the nature of experience as continually changing; the active role of people in shaping the worlds they live in; an emphasis on change and process, and the variability and complexity of life; and the interrelationships among conditions, meaning, and action (Strauss & Corbin, 1990). Grounded theory is a vigorous process which, though not linear, involves the following stages: data collection and sampling, selective sampling (theoretical sampling); memoing; theoretical coding; diagramming; and finally writing up the report. Diagrams represent a visual organization of categories and their linkages (Corbin, 1986). Basic social processes are then explicated from identified themes and categories. The ultimate goal of analyzing data for process is to account for change in the social phenomenon under study (Fagerhaugh, 1986).

Grounded theory rests on the theoretical framework of symbolic interactionism. The use of such a theoretical perspective requires the researcher to view social change and problems in light of their social interaction and within their social context, because meanings are seen as social products created and formed "through the defining of activities of peoples as they interact" (Blumer, 1969, p. 5). Because the focus of symbolic interactionism is on interaction, we are able to understand behavior in new and different ways (Chenitz & Swanson, 1986).

Rationale for Using Grounded Theory

There are several reasons that grounded theory methodology was selected as the theoretical perspective to study the experiences and needs of family caregivers in the face of social changes sweeping through Botswana. First, the grounded theory approach is especially suited to family caregiving because this phenomenon is an action oriented process. Nurses using grounded theory in the study of the elderly have contributed important perspectives that have broadened the understanding of the caregiving process beyond a set of tasks (Given & Given, 1991).

Second, qualitative methodology is recommended where there is little information on a phenomenon . As documented in the literature review, information on caregiving in Botswana is sparse. The concepts elicited from a qualitative study may then be used to develop questionnaires and tools which can be used to assess caregivers in further quantitative studies of the elderly.

Finally, the ultimate goal of grounded theory is to generate theory. This is an important aspect of the methodology, one which lends itself well to the development of theories by Batswana nurses upon which their nursing practice can be based. Yet these theories must be culturally relevant, compatible with the social era and capable of guiding nursing education and practice (Mandelbaum, 1991).

This approach is further well suited to the study of family caregiving because of the fact that this phenomenon is an action oriented process. It is for this reason that grounded theory methodology was selected as a theoretical perspective to study the experiences and needs of family caregivers in the face of social change sweeping through Botswana.

Setting and Sample

Primary data sites included one urban area and two rural areas: 1) Gaborone, the capital city of Botswana, which is an urban area in the south with a population of 133,791; and 2) Kalamare and Shoshong, with populations of 5,592 and 1,500 people, respectively (Central Statistics Office, 1991). The two rural villages were located in the central district of Botswana.

Table 3-1

Geographic Location of Sites and Numbers Recruited

Site	Number	%
Shoshong	10	42%
Kalamare	4	17%
Gaborone	10	42%
Total	24	100%

Criteria for Sample Selection

The proposed criteria for study participation were: 1) being a primary caregiver of an elderly person ("primary caregiver" defined as the person with the overall responsibility for the actual care or supervision of an elderly person who was 60 or above); 2) an ability to speak Setswana; and 3) having been a caregiver for at least three months. This definition was arrived at in the absence of a universally accepted definition of "primary caregiver." Restriction to the primary caregiver model is problematic as it may lead to an underestimation of the contributions of other persons involved (Keith, 1995). However, informal participant observation and interviewing of the caregiver helped to alleviate some of these problems. Furthermore, where caregiving was shared among various family members, the contributions of other family members were elicited from the primary caregiver. In four instances, other family members who participated in the care came forward and asked to be interviewed.

As originally conceived, only those individuals who were designated caregivers were to be interviewed. However, due to the collective nature of Batswana society, this was not always possible or appropriate. Occasionally, group interviews (N=4) became necessary. As 40% of the rural households are headed by females, an effort was made to include caregivers from male-headed households as well.

Table 3-2

Demographic Characteristics of Caregivers

Age of Caregivers	
Mean	49 years
Range	23-74 years

Table 3-3

Gender of Caregivers

	Number	%
Male	2	8%
Female	22	92%
Total	24	100%

Table 3-4

Relationship of Caregiver to Care Recipient

Relationship	N	%
Daughter	14	58%
Sons	2	8%
Niece	1	4%
Grandchild	1	4%
Wife	5	21%
Neighbor	1	4%

Table 3-5

Age Distribution of Care Recipients

Age	Number	%
60-69	3	12%
70-79	8	32%
80-89	8	32%
90-100	6	24%
TOTAL	25	100%

Recruitment

In both rural and urban settings, participants were initially sought with the help of the Family Welfare Educator and social welfare workers and, thereafter, by the snowball technique. Early participants were asked to identify other subjects who would be eligible for the study. Nurses who worked with various families in different settings were requested to make referrals. However, this method of recruiting may have bypassed those family caregivers who exclusively used ethnomedical health care rather than the biomedical model of care.

Sampling

Both convenience sampling and theoretical sampling were used in this study. In grounded theory, one seeks to sample incidents and events that are indicative of developing theoretically relevant concepts (Strauss & Corbin, 1990). However, given that there was no listing and descriptive demographic characteristics available for family caregivers or elderly people at the time of data collection, theoretical sampling was not easily done. Rather than achieve statistical representativeness, the aim was to ensure the representativeness of the categories of the major aspects of people's living situations.

To the extent possible, an attempt was made to use theoretical sampling to guide participant selection. Thus, because the study was designed to explore the primary caregivers' experiences of caregiving, in order to capture a range of variation of experiences, theoretical sampling was based on comparisons between rural and urban groups and also directed by a comparison of living arrangements and other salient categories that emerged, e.g., socio-economic status.

Unfortunately, most participants who were identified with the help of the social workers were either destitute or of low income. An effort to recruit more middle income family caregivers through urban clinics located in high income areas failed for two reasons. First, elderly patients from these families were brought to the clinic only now and then; they were usually transient. Apparently, they came to visit their children in the city and see the doctor and would then go back to their villages. Efforts to see two such families failed when, in both cases, the elderly person had returned to the village before an effort to recruit them for the study could take place. Second, the clinic staff explained that some high income people were able to afford to see private physicians and, therefore, did not visit government clinics. It was not possible to recruit these individuals either as they, too, sought health care on a drop in basis and would leave directly after the visit for their homes in the rural areas.

Data collection was done until the categories, which had been identified by that point in the analysis, were saturated. Saturation involves eliciting all forms or types of occurrences, with more value placed on variation than on quantity (Morse, 1995). When core categories are saturated, little of value remains to be learned through further data collection (Glaser & Strauss, 1967). Ideally, data analysis in grounded theory is done simultaneously with data analysis. However, part of the analysis and data explication was necessarily done after returning to the United States.

Data Collection Procedures

Access to subjects had to be gained by direct personal contact, since very few people have telephones in rural areas. Even in urban areas, many did not have a telephone. Therefore, in both urban and rural areas, people were approached in their homes to be asked for permission to be interviewed.

At these initial contacts, interviews and observations were scheduled for a future date. The interview was scheduled at a time that was convenient for the family caregiver and care recipient, and was conducted in their home. However, in some instances, participants granted permission to be interviewed at the first encounter.

Information pertaining to the purpose of the study, and procedure of the interview was read or given to potential subjects prior to obtaining informed consent. Informed consent was obtained by word of mouth, as only a small percentage of the population is literate. Furthermore, Batswana become very suspicious when asked for written consent, as this constitutes a lack of trust.

I also filled in a demographic questionnaire on behalf of the participants (Appendix A). An informal interview guide (Appendix B) was used to direct data collection. The interviews were audiotaped.

Participant observation was also used. Tasks that were done for the care recipient, persons who did the tasks, and the processes used to accomplish these tasks were observed in so far as it was possible to do so. Inclusive field notes were written following each interview. If there was no time to write these out, they were taped immediately and transcribed later.

Participant/Researcher Interaction

The major tool for data collection in qualitative research is the self (Lipson, 1991). The use of an interview guide and other data collection means only serve to facilitate the interview process.

The data collection strategy that had been proposed in the CHR protocol called for a one-on-one interview with the primary caregiver of the elderly person. The rationale for this approach was that, given the limited resources of the researcher and the extended nature of the African family, it would be better to interview one person who would serve as a representative of the family. However, some participants preferred to be interviewed together with the other family members who were thought to be significantly contributing to the caregiving situation. Although the investigator worried about obtaining candid information in a group situation, this was interpreted as a reflection of the view that caregiving was not an individual endeavor, but a collaborative endeavor. This view was also deeply embedded in the culture of the Batswana.

In the community setting, particularly in a home, the researcher is a guest and is consequently guided by the social and cultural conventions governing treatment of guests. In the Setswana culture, especially in the rural areas, people do not usually make appointments but rather just drop by. As a result, some interviews that started off one-on-one, ended up being joint interviews with two or three participants. Guests who visited the family caregiver during the interview joined the interviews if they were family and were involved in the caregiving. Initially, this was a concern as it was felt it might compromise issues of confidentiality, the consent process and remaining true to the integrity of the CHR ideals. However, since the investigator was also a guest, she had no power to control the coming and going of family members. The interview would then proceed, after the caregiver had been asked if it was acceptable to continue to talk in the presence of the person who joined the interview. In some instances, this interruption did disturb the flow of the interview.

Joint interviews had both advantages and disadvantages. In those interviews where the participants joined the interview in the middle, they served to validate the data already obtained by reiterating what had been said prior to their joining the interview. Although candor was sometimes lessened in joint interviews, the researcher easily elicited areas of interpersonal conflict, even if none of the participants mentioned them. At a convenient time, participants were usually able to privately express to the researcher the fact that there was family conflict, either during the first visit or during subsequent visits. In one incident, a participant confided that she was a third wife and wanted to talk of family issues when the other family members had gone outside. Often, this kind of sharing helped to shed light on what would normally be viewed as somewhat bizarre caregiving dynamics. Things that, to that point, had not made sense would suddenly fall into place. This was more the exception than the rule in most joint interviews, however.

Another advantage of joint interviews was that a second or third individual might add important details and, therefore, provide a more accurate picture than that obtained from the primary caregiver alone. For example, one participant might respond, "yes there is a toilet," while the second would add, "yes, we have two but neither one works because they are both full."

Quite often, information pertaining to what seemed to be unvoiced difficulties associated with executing caregiving tasks would be brought up by another participant. One man, for instance, mentioned how he helped with the turning of the elderly person because both caregivers were females. The interactions among the participants yielded insights about information pertaining to decision making processes, authority, assignment of tasks and other contextual issues relevant to the caregiving situation.

Some of the individual participants were very articulate while others said little in spite of probing questions. Sometimes this could be attributed to personality differences as opposed to differences inherent in individual vs. group interviews.

The physical layout of some homes also merits discussion. Some homes were very small consisting of two or three rooms or one-room huts. This meant that interviews were conducted in the compound or under the shade of a tree. Sometimes there was no privacy, and in some instances, a neighbor or relative would walk in in the middle of the interview. They would first greet and then proceed to sit and chat with the participant. After their departure, it was sometimes difficult to recapture the momentum of the interview. This problem of disturbance was most pronounced in those families who sold traditionally brewed alcohol for a living.

Word of the presence of the investigator spread very fast in the villages, in some cases even prior to the arrival. On seeing the researcher, people would voluntarily offer information pertaining to some of the caregiving dynamics. While this may have validated information already obtained, it often interrupted the interviews. In some instances, as the participant chatted with the visitor, data that was pertinent to the study and had not been divulged to the researcher would be shared; for example, feelings about caregiver burnout.

The researcher also remained culturally sensitive to participants' beliefs about traditional medicine. Family caregivers who opted for traditional medicine rather than western medicine were not criticized. The researcher adopted a nonjudgmental stance to reports of use of traditional medicine. The researcher strove to be sensitive to the emotional strain associated with caregiving. Some caregivers had recently experienced the death of a close family member, and would cry in the middle of the interview. On such occasions, the researcher always offered to stop the interview, but the participants usually insisted that they wanted to continue. Consequently, they would sometimes carry on a conversation and cry at the same time.

In a few instances, the elderly people did not meet the study criteria. This might become clear at the beginning of an interview. However, because these elderly people were experiencing intense pain and sorrow, it was standard practice to stay on until they had calmed down and regained control, and then to try to refer them to an appropriate source for help.

One person requested that she not be tape recorded and her request was honored. The researcher instead took notes as the participant spoke. On two occasions, although participants had given consent to be recorded, they exhibited uneasiness as the interview unfolded. One participant kept glancing nervously at the tape recorder as she spoke. In such a case, the recorder was immediately turned off and packed away out of sight. Usually, this resulted in a much more relaxed interview. Another participant expressed fear of being broadcast over the radio after giving a sparse interview. Clearly, some of the people interviewed felt very vulnerable and worried about being manipulated.

Triangulation

Triangulation is a process of using multiple approaches to clarify meaning, verifying the repeatability of an observation or interpretation (Stake, 1994). Denzin (1970) believes that the ultimate purpose of triangulation is "to overcome the intrinsic bias that comes from single-method, single-observer, single theory studies" (p. 313).

There are many interpretations of triangulation in the literature. Denzin (1978) identifies four basic types of triangulation: data, investigator, theoretical and methodological triangulation. In the context of this study, triangulation was used to achieve completeness rather than convergence within the data set. Methodological triangulation could not be done because only qualitative data could be used to answer the research question at this time due to scarcity of data on family caregiving in Botswana. Data sources included time, person, space, and situation which represented individual perspectives over time and across a variety of situations (Knafl & Breitmayer, 1991).

Time

The study occurred over a period of several months, although the study was a cross-sectional one. This seemed appropriate for this study as it reflected the impact of different activities over time on caregiving demands, given the seasonal lifestyles of some of the caregivers. It was difficult to get an interview with some caregivers around ploughing season as they were away in the fields. According to Hammersley & Atkinson (1991), data recorded at different times need to be examined in light of their place within the temporal patterns, short or long term, that structure the lives of those being studied. In the rural areas, three elderly people were found alone during the plowing season as their caregivers had gone to till the lands. Actions are embedded in temporal contexts and these may shape them in ways which are important for the analysis.

Person

Interviews and observations were used as deemed appropriate for the caregiver and care recipient. Information about other services available to the caregivers was also collected from nurses, family welfare educators and members of both the city and district councils. Caregivers' neighbors and families who dropped in to visit sometimes volunteered information pertaining to the interview. This also provided data which further helped to densify the evolving theory.

Space

Interviews and observations were planned in such a way that they occurred in the home which the caregiver and other family caregivers were currently living in, and where family activities were situated. However, caregivers who were at their lands were requested to come to the main village for the interview as the roads leading to the lands were usually bad, even for a four wheel drive vehicle. Urban dwellers were interviewed only in their homes. Caregivers who did not live with an elderly person were interviewed in their homes.

Interviews were transcribed and analyzed in Setswana. Following this, five interviews were then translated into English. This helped to preserve the integrity of the data as some meanings and nuances were lost in the process of translation. A retired Setswana teacher and two senior nurses who were fluent in both English and Setswana were also asked to assist with the translation to ensure that a reasonable effort at semantic equivalence was achieved.

Analysis

Some preliminary data analysis was done simultaneously with data collection and coding in accordance with grounded theory tenets, but more was done later, with the help of faculty members and colleagues upon my return to the United States. This approach facilitates the discovery process and allows research questions to evolve in response to the emerging theory (Strauss & Corbin, 1990). Consequently, the analysis helps to focus the research questions by transforming them during the research process (Bowers, 1987).

The initial data analysis was essentially descriptive as this was done in Botswana with occasional electronic guidance from my committee. The bulk of the data analysis, particularly axial coding, was done after data collection upon my return to the United States where I received more guidance and feedback, as communication was then easier.

Initial analysis began with line-by-line open coding to elicit categories. The properties of the categories were then listed and dimensionalized. Categories were clustered into related concepts. Emerging patterns and themes were then identified. Data collection continued until saturation occurred. Further analysis was again done several times with the committee members.

Axial coding was done by making connections between categories in a systematic manner. The codes were then compared to other theoretical codes. At the same time, the conditions of the categories were also classified as strategies, causes, context, contingency, consequence or non-consequence.

The technique of constant comparative analysis was used to identify relationships and variations in the data, and to conceptualize interactional processes. Selective coding was done to identify the core category, or central phenomenon. Diagramming of categories was also done. Diagrams represent a visual set of categories and their linkages (Corbin, 1986). Basic social processes were then explicated from the identified themes and categories. The ultimate goal of analyzing data for processes is to account for change in the social phenomenon under study (Fagerhaugh, 1986). The analysis was also described in memos as it unfolded. The literature which fit the emerging theory was then selected for review.

The Discovery Process

Discovering or constructing the grounded theory was an intense process in and of itself. At first, I thought the family caregivers were coping with challenges, the challenges being poverty and lack of access to health care. Then I thought they were coming to terms with caregiving. All the while, I worried about the poverty in which most caregiving was done. As I looked more closely at the data, I was intrigued by how the family caregivers were giving care under overwhelmingly difficult conditions without complaining, or even asking for much. Committee members questioned this occurrence from a cultural point of view and it was at that point that I made the connection. From these exchanges came the category "endurance in silence." Analyzing the way care was organized initially elicited the caregiving system models as the core category. "Caregiving on the edge" was later decided upon as the core category, in light of the poverty and socio-cultural events that caregivers were confronting. The interaction of the family caregivers with the health care system was also a sub-theme of caregiving on the edge.

Establishing Rigor

The credibility of nursing science depends on the rigor and quality of scientific work (Gortner, 1980). According to Sandelowski (1986), the truth value of a qualitative study resides in the discovery of human experiences as they are lived and perceived by subjects, rather than in the verification of *a priori* conceptions of those experiences. Guba & Lincoln (1985) suggest that the truth value is determined by how credibly the researchers construct reality, and that credibility should be the criterion against which the truth value of qualitative research should be evaluated, rather than internal validity.

Credibility

Credibility assesses how vivid and faithful the description of the phenomenon is (Beck, 1993). Credibility is established when such faithful descriptions of human experiences are presented that the people having that experience would immediately recognize it from those interpretations or descriptions (Sandelowski, 1986). In grounded theory approaches, credibility is embedded in the analytical procedures. According to Glaser and Strauss (1967, p.223) "comparative analysis and different slices of data correct the inaccuracies of data."

Verbatim transcriptions of audio-taped interviews and the use of quotes in the report achieved credibility by grounding the findings in the data. The analysis group, composed of faculty members and some students in the United States, read the memos documenting the evolving process as well as the interview scripts to collectively validate that the findings were indeed grounded in the data.

Insider Bias

Insider research is considered inherently biased (Aguilar, 1981). According to Becker (1977), we take sides as our personal and political commitments are clarified. To minimize researcher bias, he proposes ways to attempt to methodologically represent the other as they see themselves rather than as we see them. He suggests that this can be done by delimiting the boundaries beyond which our findings cannot be generalized, and by attempting to use our theories and techniques impartially. Reflexivity and the input of my committee in the analysis minimized bias.

Reflexive Journal

A reflexive journal is a kind of a diary where an investigator records information about himself or herself on a regular basis (Lincoln & Guba, 1985). Information about my schedule, logistics, insights and reasons for methodological decisions were maintained on a regular basis in such a journal. This helped me to keep track of my feelings and, hence, to avoid biases. It also helped to serve as a rationale for decisions taken in data collection, such as the need for justification of theoretical sampling.

Validity

Glaser & Strauss (1967) advocate a face validity measure of sharing the developing grounded theory with study participants and rating their reactions. Member validation is a procedure which seeks to verify fieldwork findings by taking them back to the members whose worlds they describe and analyze to see if members recognize and validate the accounts (Bloor, 1986). I took the findings back to one of the participants for member validation. Given the low literacy rate in Botswana, member validation was done by reading a summary of the findings to her. She said that her situation was as I had described it except that her mother had since deteriorated rapidly since the previous visit. At a meeting with some of the staff members of one clinic, I gave a report of the preliminary findings and some of the health related findings were validated by the staff. They saw the need for continuity of care in the community following discharge from the hospital, not only for elderly patients but for all patients. They shared experiences, particularly of Auto Immune Disease Syndrome (AIDS) patients whom they had run into by chance during their home visits, and mentioned that these patients needed community-based support. The ongoing literature review is a strategy that addresses construct validity within grounded theory (Atwood & Hinds, 1986).

Peer Debriefing

Analysis of data with members of my committee, and other students in a group seminar at the University of California San Francisco, was done to validate the findings. Peer debriefing helps build credibility by allowing professional peers to analyze the data, test working hypotheses and emerging designs, and listen to the researcher's ideas and concerns (Erlandson, Harris, Skipper & Allen, 1993).

Other plans for ensuring rigor included triangulation and checking data for representativeness as a whole. Coding categories were checked to see if they were grounded in the data, by going over all the interviews again.

Auditability

Auditability was another strategy of ensuring rigor. A study and its findings are auditable when any reader can follow the progression of events in the study and understand their sequence and logic. Auditability of qualitative research requires a complex collection of four types of documentation; contextual, analytic, methodological, self awareness and reflexivity (Rodgers & Cowles, 1993). This was achieved by writing a comprehensive report, including all that went into conducting the study, from beginning to end. In this study, the audit trail comprises coded interview scripts in Setswana and some in English, documented analytic codes, and memos documenting the evolving process. Memos of fieldwork, documenting the frustrations and celebrations of data collection were maintained as well as memos of analysis done both in the U.S. and in Botswana. These documented the evolving process.

Ethical Considerations

Measures were taken to maintain confidentiality. Confidentiality of data was maintained by assigning participants numbers for identification purposes. Only numbers and initials were used on participants' tapes and demographic forms. Any identifying information such as name, ethnic group, or location of residence were removed from transcripts. All taped interviews and transcriptions were kept in a locked cabinet. Only the investigator had access to addresses of participants.

Participants were made aware that participation was voluntary. The researcher was vigilant for any signs of emotional distress during the interview. For example, a participant would terminate an interview at any time if she/he felt uncomfortable or expressed a desire to discontinue. A copy of the Information Sheet (see Appendix C) was given to the participants.

In the U.S., research procedures to conduct research in Botswana were approved by the Committee on Human Research at the University of California, San Francisco (see Appendix D). In Botswana the Office of the President, Ministry of Health, and Ministry of Local Government and Lands, approved the research procedures (see Appendix E).

As far as possible, privacy was sought for conducting interviews during data collection. However, this was sometimes hard to do with friends and neighbors dropping in on the caregiver. A signed agreement regarding protection of confidentiality was made with the person who did the transcriptions. Group members with whom the data was shared were made aware of the confidential nature of the interviews.

Methodological Problems

Translation

Some authors have discussed the frustration, ubiquity, and difficulty of the translation problem (Brislin, 1980; Loner, 1980). Richards (1980) echoed my feelings regarding translation when he asserted that translation is "probably the most complex type of event yet produced in the evolution of the cosmos" (p. 25). Translating the data from Setswana to English posed a real challenge. Consequently, data was analyzed in Setswana then later translated to English in order to share the data with my committee members.

In translating, it was very difficult to know just when to literally translate at the expense of preserving meaning or when to paraphrase what the participants had said without changing the meaning. Some expressions were idiomatic and could not be explained well in English. One participant reported that he had had to temporarily abandon his father in order to go and look for work. He mentioned that, while he was away, his father talked with the heart. If one did not literally translate this, it could be said that his father remained preoccupied with his absence while he was away. Yet, to do so, would change the meaning completely. In Setswana context, talking with the heart indicates that aspect of the self which can be engaged in social interaction between the self and the presenting situation. What matters in such talk is not psychology as it is understood, but the passions generated in a self (Rosaldo, 1989).

In spite of the back translation that is advocated, some meanings are lost in the process because some colloquial expressions simply cannot be understood cross-culturally (Edwards, 1994). Consequently, this may have interfered with the way the data was portrayed. To the extent possible, linguistic and conceptual equivalence was maintained in the process of translating.

Casagrande (1954) described four types of translations and their goals: pragmatic, aesthetic-poetic, ethnographic, and linguistic translation. In a desire for quality translations, all the four types were employed to a greater or lesser extent. This was necessary as it was important to introduce the context into the translations. Any one translation can rarely be categorized into only one specific type (Brislin, 1980).

However, it remained a constant challenge to try to achieve the aesthetic-poetic translation. This is when the translator takes into consideration the affect, emotion, and feelings of an original language (Brislin, 1980). Meanings were often lost in the process of translation--not only literal meanings but also the accompanying emotional meaning. Quite often, after reading poignant accounts of caregiving situations in Setswana, it was simply not possible to capture or convey the same emotion in English. Certain nuances were always lost in the process of translation. Some translated text may seem redundant. Part of this may be the result of the way the participants communicated. The redundancy was sometimes necessary in order to preserve the context or for purposes of emphasis. Context and redundancy in the original language version have a major effect on the quality of the translated version (Brislin, 1980). Repetition is part of the poetics in Setswana, but because it is not a convention of emotional expression in English, it appears as redundancy in translation and cultural content is lost.

Doing Research in the Researcher's Own Culture

The input of my committee members in the analysis was invaluable. It is very difficult to do research in one's own culture, because one is often blind to some of the things that are going on. This may, in part, be related to the fact that one can become so embedded in a culture's micro and macro social worlds that certain events, key to the analysis, are completely overlooked.

For instance, committee members realized from the beginning that poverty was pivotal to this data and pervaded many aspects of the lives of the caregivers. The outsider, it seems, is often quick to notice certain events the relevance of which is lost on the insider. Another theme that was common throughout the management of the caregiving experience was abandonment. Abandonment by other potential caregivers undergirded the individualistic caregiving system and other aspects of managing the caregiving experience. This investigator could not see that in the beginning.

Meanings are contextually grounded. Therefore, it is important to not neglect cultural frameworks of meaning in eliciting and interpreting responses (Mishler, 1986). Often, themes easily noticed by outsiders had to recurr many times before I became aware of them. Perhaps, I made the mistake of assuming I was an insider when, in fact, I was not. Having now been exposed to African, North American, British colonial, and nursing cultures, I am a syncretic border woman. In contemporary discourses of postcoloniality, Jan Mohamed (1992) delineates two kinds of postcolonials: the syncretic intellectual and the specular border intellectual. He defines the former as one at home with several cultures, able to combine elements of those cultures in order to articulate new syncretic forms and experiences.

Although the researcher may be a native of the culture under study, it is possible to suffer culture shock when one steps out of their practitioner role into the role of an observer (Field, 1991). For those events which were surprising to me or quite negative, my initial reaction to them was denial. I clearly remember thinking (in English!), "No, this is not happening in my culture, not in Botswana," when I witnessed the first incident of an elderly person being verbally abused by her children. It is interesting how a bilingual will think about different things in different languages, depending on the task at hand . In a society that has traditionally given the elderly people great respect, the act of witnessing quite the opposite in the presence of a stranger can be disturbing, indeed.

In a similar vein, I found myself from time to time in denial over the issue of a family caregiver reporting mistreatment at the hands of a registered nurse. Being reflexive about the incidents at hand and writing down one's reactions to these events was one way of dealing with this denial. Through the process of analyzing why I was feeling and reacting as I was, I achieved a greater awareness of my emotions and became better able to pay attention to those events which were culturally or professionally disquieting.

Talking to other Batswana nurses whose interests were less vested in the study was also very useful. These nurses did not experience the same denial when presented with the same data. They were able to acknowledge unemotionally that instances of the abandonment of the elderly and ageism were becoming more and more common in Botswana.

The Researcher and the Research Process

I am a Motswana woman whose interest in family caregiving is rooted in several important life and career experiences, as well as in my academic training. First, I took care of my late grandmother in the final stages of her illness until she died. This personal experience first exposed me to the notion of family caregiving. Second, I worked in the Intensive Care Unit (ICU) and did clinical teaching in a medical ward and community health settings. These experiences sensitized me to issues of ageism and the problems of the elderly. I still vividly recall the night I called the doctor about a deteriorating 80 year old woman who was in the ICU. He did not come; rather he told me to take her off the ventilator as she was not likely to live anyway. Third, I did a survey of the conditions under which the elderly lived in southern Botswana in partial fulfilment for the Bachelor of Education programme. I was surprised by the level and degree of poverty among the elderly people which this survey revealed.

Shortly after starting data collection in one of the poorest areas of the city, I found myself experiencing burnout. Maintaining a necessary distance in the face of such poverty and the struggles experienced by family caregivers proved extremely difficult. After these encounters, I would typically seek comfort at the end of each day by going to church in the city. I found I needed a higher power to help me understand what I was seeing and of whom I could ask for help for the families.

At certain times, I reflected on what might come of this study. I questioned if any useful policy would be implemented as I had hoped or if, in the final analysis, this was just an exercise to facilitate my obtaining a Ph.D. I questioned whether I had chosen the right topic and what wisdom there might be in going back to school to find another topic. This particular thought haunted me. As a result, I stopped data collection for six weeks. Also about this time, I attended a three weeks course in Malta on gerontology in Third World countries. Attending this course was a turning point in my data collection. It was at this time that I decided to commit myself to the task ahead and to have faith that the challenge was not insurmountable. I realized that many developing countries were also faced with the problem of aged people whose care had been compromised by rapid social change. I learned during this period of simple but effective programs which had been implemented by other countries in an effort to deal with the problem of an increasing elderly population.

The primary caregivers in this study were mostly women and this was culturally appropriate in the Tswana tradition. The research interview as a collaborative process can be aided by gender, class, and cultural congruity (Riessman, 1991). However, gender congruity may not be sufficient to overcome the culture of science which the researcher may bring to the interview, and the joint construction of an account of caregiving may be hindered by the lack of shared class assumptions (Riessman, 1991). I sincerely hope that this did not affect the responses of the caregivers and, having looked now carefully at the data, do not think that it did.

In the mainstream research tradition, the interviewee-interviewer relationship is characterized by a striking asymmetry of power. As a nurse scientist from the University of Botswana, there must have been some power asymmetry between the participants and myself. I attempted to correct this situation by empowering the respondents. To be empowered is not only to speak in one's own voice and to tell one's story, but to apply the understanding arrived at to action (Mishler, 1986). Through the principle of community participation, the understanding of caregiving can be applied to action by mobilizing community resources.

Being observed often carries with it the threat of judgement or evaluation (Field, 1991). It has been my experience as a community health nurse that people in the community often associate a nurses' drop-in home visit with an inspection of hygiene or health related evaluation. This problem was rectified somewhat by making appointments with the families for interviews, rather than just dropping in. Unfortunately, given the absence of telephones, I did have to drop in on the caregivers initially to make the first appointment.

There is a tendency to concentrate on clinical observations rather than capturing the interactions which are critical to the study and occurring all around you (Field, 1991). I found I was making a conscious effort to shift the focus to the caregiving interactions, and not to evaluate other health related matters, difficult as this was. I ended up helping four families who were experiencing more acute health-related problems, as it was difficult to separate that from the research. In addition, when a caregiver was unwell, I always asked if he or she was on treatment. I found it important to respect their response, even when this included information that they were using a traditional medicine .

Limitations

Being a lone researcher and not a part of team is, in and of itself, a disadvantage in qualitative research. Records of detailed memos and field notes were written immediately after the interviews and maintained. On-going communication and consultation with the committee members in the United States on several principles was done periodically by electronic mail.

The main limitation of this research was the relatively small and not always representative sample size. Interviews were mainly limited to people of low socio-economic status, particularly in Gaborone. This makes some of the findings of the current research probably inapplicable to the caregivers within the middle and higher socio-economic status. There were only two male caregivers in this sample. More male caregivers need to be included in future studies. More male care recipients should also be included. However, the patterns described may reflect cultural patterns of the gender-specific nature of caregiving and a demographic profile of the sick elderly.

There was no formal national or local listing of either caregivers or homebound elderly care recipients at the time of data collection. For this reason, the researcher relied on social workers and family welfare educators for identification of participants. In Gaborone, FWEs are reassigned annually. Consequently at the time of data collection they were not familiar with their communities. Identification of elderly people was very time consuming. Although the social workers had a listing of elderly people, these were mostly registered with them as destitute, or in need of certain services from them, hence the high number of low socio-economic study subjects.

Caregiving is a process and, therefore, interviewing the caregiver once was not sufficient to capture the full scope of caregiving. This snapshot of reality does not fully capture the processes through which the phenomena of family caregiving of the elderly develop. Some caregivers were interviewed at the beginning of their careers, some in the middle, and some after a lengthy experience. Two or three spaced interviews with each caregiver would have captured the transition of the caregiving process and may be a useful part of any future research in this area. I did have an opportunity to visit four families more than once; these families had problems which needed follow-up. One caregiver, for example, needed help with the transporting of her mother to the clinic. In several subsequent visits, I observed her mother deteriorate and saw the emotional toll this took on her. During my final visit, she appeared very depressed, a sharp contrast to my first visit with her in which she complained only of a lack of food and money.

CHAPTER FOUR

CAREGIVING ON THE EDGE

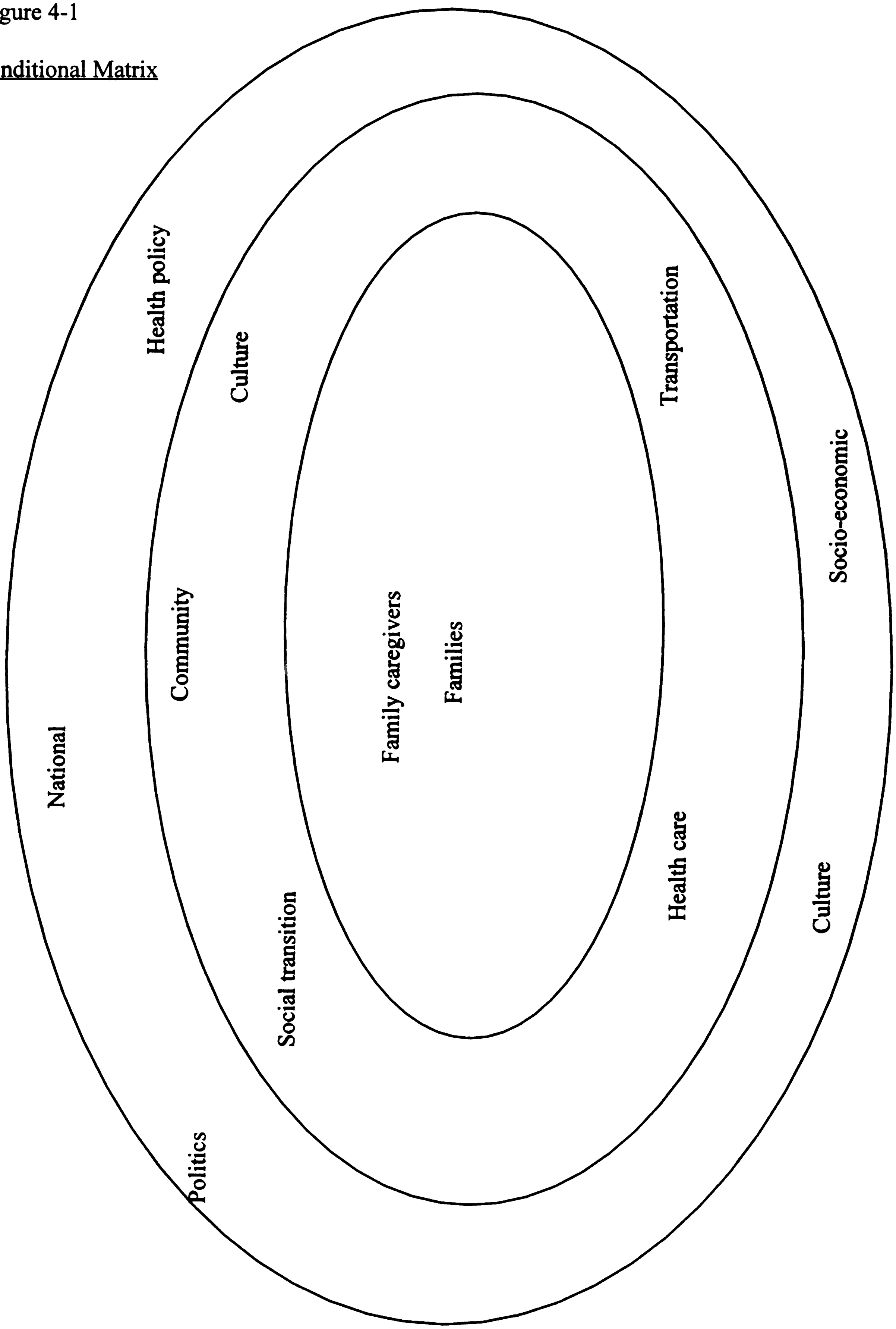
Family caregiving in Botswana is occurring within a dynamic and changing socio-cultural context, but one that, for the caregivers interviewed for this study, was steeped in poverty. Caregivers were struggling with basic survival needs under poor socioeconomic conditions, were caught in the social transitions that the country is undergoing, and lacked access to health care. Thus, the core category that emerged from the data was "caregiving on the edge." This chapter develops this core category and three subcategories. First, the conditional matrix which represents the socio-economic, political and cultural context within which caregiving was occurring is further developed to lay the framework for the results. Then the core category is developed along with its subcategories and their dimensions. Subcategories include: on the edge of survival; cultural borderlands; and on the outer boundaries of health care access.

The conditional matrix (see Figure 4-1) represents the socio-economic, political and cultural context of caregiving under which the family caregiving of the elderly is taken on and managed by their caregivers. It illustrates how caregiving is embedded in a traditional culture in a changing society. The role of the socio-economic and political system is discussed to illustrate its impact on the family and care of the elderly.

Each family has a structure, specific living arrangements, and a certain number of resources. In each family is found an individual caregiver or team of caregivers. These individuals may live together, or at a distance. Family caregivers relied on their own

Figure 4-1

Conditional Matrix



sources of income which were supplemented by contributions from other family members. However, reliance on family remittances is uncertain as some family members, although they may be working, may be unable to contribute much to their family's financial well-being if they are also caught in the web of poverty. The ability to provide adequately for an elder relative depended on family resources as well as the dynamics of sharing caregiving activities. Consequently, the socio-economic conditions are inextricably linked to family caregiving.

The communities where these families live are located within a larger world where poverty is rife. The communities in the rural areas were characterized by a much less developed infrastructure, and transportation was a serious problem. This lack of infrastructure and transportation resulted in limited access to health care for many elderly people.

Health policies established at the national level set the trend for local health practices. These health policies are approved by the politicians. The health care delivery system, although in principle available to all ages, is also situated within this poverty stricken social world. The economics of the country determine the budget of the Ministry of Health, and to a large extent, what goals can be successfully achieved by the health sector, given certain budgetary constraints. The health practices of the health care system cannot be successfully implemented due to a shortage of transportation, lack of a well developed infrastructure, and policies that are set by the Ministry of Health. Consequently, lack of services such as home-based care or community-based care for the elderly adversely affect the health of elderly people as many of them do not have the means to seek care in the clinics.

These families are also situated in a community and society with cultural norms or expectations regarding the care of the elderly person. Such cultural norms are not static; some of them are going unfulfilled and being transformed as the country undergoes social change. The traditional Setswana culture emphasized kinship, reciprocity and care of the elderly by family members. In recent years, the number of elderly have increased. At the same time the rate of rural to urban migration of family members has increased, leaving many elderly to fend for themselves in the rural areas. Although the traditional collective way of life is still more prominent in the rural areas than in urban areas, there were instances of a shift towards individual family styles even in the rural areas.

The demographic transition is challenging the fabric of a culture that purports to take care of its elderly. As more people search for and find better jobs in the city, rural multi generational families and households are slowly disappearing. This demographic shift also has an impact on the subsistence farming so vital to rural families because the manpower necessary to work the farms is no longer available. Thus, while the initial assumption was that caregiving occurred within the extended family, this did not hold true.

On the Edge of Survival

Caregivers were surviving on the edge because they were battling with pragmatic matters of everyday living, like securing food, water, shelter and sanitation. They were faced with the dilemmas such as choosing whom to feed, and whether to compromise food for other necessary services like shelter. What emerged from these data is the importance of being able to provide for the elderly. Family caregivers who were unable to provide for an elder agonized over this. Being a caregiver of an elder relative meant being able to provide for them, since elderly people were considered the same as children, both groups had to have their needs met on a regular basis.

The Acknowledgment of Poverty

Many caregivers did not have formal employment although some were involved in small businesses that earned them a very small income. Some were also involved in subsistence farming. Quite a number of caregivers had given up farming and care of livestock entirely in order to take care of an elderly relative. This tended to worsen their poverty, since those relatives who might has assisted with the farming had long since moved to the cities. Many saw no alternative to their caregiving obligations, even if this meant giving up their livelihood and plunging themselves into a life of poverty.

This caregiver acknowledged that she fell short because of their economic status:

> We are not able to give her much of the food that is needed. We fall short because we are also ordinary people who do not have much. (CG18)

Several caregivers were aware of, and spoke directly of, their low socio-economic status and that of their relatives. In some instances, caregivers did not anticipate help from their relatives who were in much the same position as they were:

> There is no help from relatives, really they cannot help in anyway because they also have nothing to offer. They are just as poor as we are, so anticipating any financial help from them is a bit unrealistic. They have nothing to give. (CG07)

This caregiver was aware of her double jeopardy:

> There is no one who can help. When you are poor and have no one to help you it is...like I said, I have no parents, and my husband has no parents either. Since this illness began, no one has ever come here... (CG08)

The low socio-economic status was worsened by lack of extended kin and better paying opportunities. Most of the caregivers were not educated and, therefore, limited in terms of job opportunities. Their level of education ranged from 0-7 years of education. As one caregiver explained:

> The kind of job of working as a maid does not bring in much income. When someone pays you 150 Pula ($50) a month, when you have to distribute that money over several things in the home, it cannot make much of a difference. I really wish I had gone to school. I wish I could go now. I wish I could get a job in a secondary school, but I am not educated.

As caregivers left jobs to give care or changed occupations, their socio-economic status declined further and they acknowledged the concomitant difficulties which this entailed:

> The difficulty related to taking care of my aunt, I can say that it is difficult because I am poor. Because if people are poor, it becomes difficult, because she is an adult.... All I can say is things are difficult because I am poor, or maybe I should say that because our financial situation has declined, because in previous years, God used to help me. I was able to get money, and provide for her if she said she wanted this and that. Now I do not have even a cent. I cannot even go and borrow money because if I did what would I repay the money with? (CG10)

Very few caregivers were employed at a formal job (21%). The rest (41%) were engaged in subsistence farming (17%), small businesses like selling snuff, cigarettes, grass for thatching, traditionally brewed alcohol, and 21% were homemakers. The poor socio-economic status of the caregivers put them in a predicament because this had an impact on their ability to fulfill their caregiving responsibilities.

Caregiving and Unfulfilled Survival Needs

Caregiving, to most of the study subjects, was equated with "providing for the elder relative." The elderly were viewed by most as family members who needed providing for on a regular basis, much like children. Failure to fulfill this role entailed a lot of emotional pain for the caregivers. Caregiving on the edge was exemplified most immediately in the caregivers ability to provide three things directly associated with survival: food, soap and shelter.

While it was anticipated that most caregivers would ask for assistance with hands on tasks, most caregivers, in actual fact, sought assistance with food. Caregivers were concerned with meeting basic needs that were at a very low level, like food and shelter. Maslow's hierarchy of needs was well illustrated by these caregivers who were concerned with basic needs maintenance. This was expressed by several caregivers when asked what they thought could best help them. Most of them replied that they thought making food available or helping them with food would be very helpful. When two caregivers were asked about what they helped the elder person with, they mentioned this in relation to food:

> The care that I give is to provide my parents with food if I have plowed, then they have a life. We can only live if I have gone to plow, then we have a life. But, unfortunately, even if I plow, I do not reap much sorghum. So my parents do not live well at all. If I do not plow then they do not have a life. They live under difficult circumstances. (CG15)

When asked about what kind of assistance they thought would best help them, most noted:

> If only they could help with a bit of food, it would be better if we could be helped with food, it would really be helpful because we know that money is something that is difficult to give out, but, if they could help us with food and clothes, I think it would be better. (CG03)

So, indeed, what can be perceived as basic survival needs were not available to some of these caregivers and, if available, they could only get it some of the time.

If You Can Get the Food

In discussions pertaining to food, it was evident that food availability was not a given, but a temporally conditional commodity. Food was described as a commodity that was sometimes available and sometimes not. As one caregiver noted in reference to his father:

> He is the kind of person that, if he has, or better still if you provide him with a bit of food...... *if you can get the food*, he will stretch the food to last as long as possible. (CG16)

A different caregiver stated that she gave her mother food, "if the food was available," while still another noted:

> There is no food right now. We are waiting for the month to end, when month end comes, then mother will receive her pension check. (CG18)

In those instances where the family caregiver relied on family remittances to purchase food, this arrangement did not always ensure availability of food. One caregiver who was also relying on her children's income noted the uncertainty of this type of arrangement:

> I rely solely on my children. But they are also failing. The reason I say so is because on some days we go to bed hungry. Then on some days they are able to buy food. (CG09)

One caregiver, who was looking after her diabetic husband, lamented the problem of money as she noted the cost of a diabetic diet:

> Even with the food the doctors say he should eat, the problem is money. I have no money, we have no money. There is no one who works between the two of us. But this illness which requires foods like these (pointing at fruits), it requires certain foods. These foods are difficult, difficult my child, it is too heavy for me. As it is now, he does not eat beef anymore, he does not eat any meat except chicken. It is expensive food which I just don't have money for all the time. (CG06)

Indeed, when I spoke to one care recipient who had suffered from a stroke, I asked her if she was able to eat, and she replied:

> The heart is wishing for the food, but the stomach is empty. There is no food in my stomach. (CR09)

The experience of hunger was one which many of these families had to live with quite often. Even when it was possible to obtain the food, they were faced with the near impossible task of stretching it to feed everyone. Deciding who would receive food and who would not was part of the everyday experience of many caregivers.

Difficult Survival Choices

When there was not enough food to go around, choices had to be made as to who should go hungry and who should eat the little food that was available. Frailty and age were among the principles which governed food allocation. Often, the sick elderly person was given preference. But as this caregiver noted:

> Seeing as we are so many, it means that sometimes there is no soap to do laundry and insufficient food. Even the children sometimes they have nothing to eat when they come home from school. With whatever food is available, we try and feed the elderly person first as he is sick. If there is any left, then the children are given the plate to scrape. The rest of us adults just have to go without food. (CG07)

This kind of pragmatics was also found in those families who relied on food rations from the government. Here, too, the food received was often insufficient to last a month and decisions pertaining to food allocation among family members forced a replay of the drama on a daily basis.

Food took on an even greater importance in those circumstances when diet was part of a treatment protocol. One diabetic woman ate nothing but corn meal porridge (phaletshe) and cabbage. Her daughter explained that they had no food in the house. What their mother was eating was food that they had asked for from one of the neighbors. In this instance, a decision was made that out of the 16 people in that home, the diabetic elderly mother was the one who had to eat.

Shelter Needs

Unlike those caregivers in the rural areas, who mostly owned their homes, caregivers in the city had the added burden of paying rent. One caregiver explained that she had to forgo buying food for her elderly mother in order to be able to pay the rent. As difficult as this was, the caregiver had to make the choice so as not to be evicted from the apartment. As she explained:

> The biggest problem that I have is that even when the children have helped me with some money, I have to go and pay the Self Help Housing Office and Christian Council. Then for that month we do not have food in the house. The Christian Council already helps me to stay in this two-room house. I mean I am absolutely poor. I have nothing. I really have serious problems. (CG09)

Shelter was another of the basic needs which some caregivers strived to obtain for elderly relatives. In some instances, the elder person was already living with a relative, long before they required assistance from the caregiver. However, if the daughter was married, sometimes she preferred that the elder relative have a place of their own. One caregiver explained that her greatest wish was to build a hut for her parents so that they might have their own roof over their head. At the time of the interview, they were living with her and her husband in their small home:

> If only the spirit would grant this request...this wish of mine to provide a roof for my elderly relatives. Then my heart would be healed. Even my blood pressure would heal, because it is worsened by being preoccupied with where will these people go if I am no longer around? I worry that, if I die, my in-laws will tell them to move on, because I will be gone. (CG15)

According to tradition, her parents should have been living with their son. It was, therefore, uncomfortable to be put in this situation. Although she had brothers, she mentioned that they were too poor to care for their parents. Her husband had also expressed his discomfort with the situation.

Sanitation Needs

Other needs which were expressed by 13% of the caregivers concerned sanitation. In one home, both pit latrines were full and needed to be emptied. As one family caregiver noted:

> I have problems. During the month of March, my pit latrine collapsed, so now I have problems. My mother does not walk, so I have to take these buckets in the morning and empty them. There is another house on that side who said I could use their toilet. So every morning, and all day long, I take the bucket, just as if I am nursing her, doing everything for her. Mother is sick, unable to walk. But really, I am unable to look after her. You see, my husband also died recently. (CG14)

She mentions the death of her husband because it meant that she was now the head of the family and, as such, had limited resources with which to take care of her mother. Yet another caregiver complained about the scarcity of water in their village;

this prevented them from installing a flush toilet in the house which would have made it easier for the elder person to use the toilet. The present pit latrine was too far away for the frail 96 year old.

Government Help with Soap

Another survival need frequently mentioned was soap. Soap was an important commodity not only cleaning up after incontinent elderly relatives, but for routine purposes like bathing. However, the availability of soap also embraced a broader meaning; that of enabling the families to maintain the ritual of bathing in the morning before handling or eating food. This is an important aspect of Tswana life. Therefore, the inability to provide soap for themselves, represented not only severe poverty, but a severing of one of the most basic connections with cultural norms.

One caregiver, acknowledging that she was constrained in helping her mother, mentioned with relief that at least she obtained help from the government in this one area:

> "At least the government assists her with soap." (CG18)

What this caregiver meant was that her mother, a retired school teacher, was on government pension and, therefore, was able, at the very least, to buy soap. When asked what they thought about a proposed government pension for all old people, most caregivers mentioned that., while it did not seem like a lot of money, it would at least help to buy soap.

Unfulfilled Caregiving

The ability to provide food to an elderly person was viewed as a criteria of successful caregiving and seemed important to most caregivers. Many caregivers explained how they struggled to fulfill this caregiving responsibility: "She does not go hungry, she can only go hungry if I lack the resources to take care of her, or if I get sick." (CG16)

Yet, others, who were unable to meet the demands of the elderly relative, were often emotionally overwhelmed. The following caregiver had given up her job to take care of her elderly mother and was, therefore, dependent on her children for income. She noted:

> (Sighing) Things will gradually worsen until God only knows. Mother herself expresses signs of despair and says I must send her back to her home since it seems I have grown tired of her. Sometimes when I cook porridge for her, she refuses it, and yet I do not know where she expects me to obtain meat from? When I cook mealie meal (corn meal) porridge, she says she will not eat it. She wants this and that, she is now just like a child. Tell me, where on God's earth am I going to get those things from? I am beginning to lose patience now. Because if you cook something she does not like, she tells you that if she had still been able to, she would have cooked this and that for herself. You should just listen to how my heart feels when she says that. (CG09)

Another caregiver lamented about the fact that she could not provide sufficiently for her parents' needs:

> Because they are old people, they are almost like small children in their need to eat regularly. In the morning they need to drink something warm, eat some food in the afternoon, and again in the evening. If they can eat, their skin is good to look at even if they are sick. But, I am unable to do all that as things are not going well. That is the only thing which...I am unable to do, so my heart aches for them. (CG15)

Still another caregiver poignantly reflected on how her father sympathized with her struggles:

> Because my dad cannot walk or do anything for himself, sometimes he feels sorry for himself and says to me "God has really tortured me my child. Seeing you so sick, I could have died long ago. It makes me

> unhappy to see you groaning in pain and still having to look after me. (CG15)

Consequences of Caregiving on the Edge of Survival

Loss of Crops and Animal Livestock

Fairly common among many of the Batswana families was the use of seasonal homes. During the ploughing season, temporary homes are set up near the fields. After the ploughing season, people return to their village homes. In some instances, this seasonal move from one home to another was disrupted due to caregiving responsibilities. One caregiver observed how she could no longer go to the fields during the plowing season because her disabled elderly mother refused to go with her, asserting that she did not want to die under a tree. As a result, she had to walk the great distance to and from the fields in order to tend to both her mother and her crops. Yet, she herself was elderly and this back and forth movement meant that she, her month, and the crops all suffered from lack of attention.

Caregiving in some cases had disastrous consequences. One caregiver explained:

> Other people have reaped bumper harvests of sorghum. I am the only one who reaped nothing. Caregiving has had adverse effects because I live so far from the fields. (Her village was 50 kilometers from her land). Where I live, I am alone and have no help. When I leave either home or the fields, things come to a standstill. (CG12)

Later, when she returned to her fields after a brief absence to check on her sorghum, she found it infested by ants. However, in spite of a disastrous harvest, she complained relatively little about the caregiving situation.

Another caregiver mentioned that she had to give up her job in order to take care of her mother who had suffered a stroke.

> Yes ma'am, it certainly limits my ability to work, because even if I see you, and you want me to go and do your laundry, so I might regularly earn P100 ($33) a month, now I am no longer able to do that. (neighbor) (CG09)

Another caregiver had to give up plowing in order to watch over her demented husband.

> I no longer plow because I have to take care of him. When I have tried to plow, he harasses the children a lot. I was afraid I might come home to find that he has killed the children. I thought it would be better to stay and watch over him. (CG07)

One caregiver expressed her views on the consequence of caregiving in a particularly direct way. When asked if caregiving had made a difference in her life, she answered:

> It has made a difference. It destroys a person's mind and body. You see, if you give care for a long time, sometimes it seems as if you are mad. Even your animal livestock, eventually it disappears, the farmlands, they disappear. Truly, caregiving for a long time destroys your entire well being (CG14)

When asked how caregiving had changed her life, she mentioned that:

> Life has changed because of the illness. You see, initially we worked together (re tshidisana ka matshelo), mutually helping each other out with our lives. He could go and do odd jobs here and there, I would also either plow or engage in a small business, and I lived comfortably. I would harvest some sorghum if it was available. However, since he fell ill, I am now the one struggling alone. (CG07)

For women caregivers taking care of a spouse, it meant that the wives now had to assume the role of head of household and learn to do without income that used to be generated by the spouse. It also meant assuming a new and unfamiliar role.

> Because of the onset of his illness, we could not harvest the crops which he plowed. Worse still, the floods washed away the fencing from our fields. I shall have to find help to rebuild the fence, but I am not sure

> where I will get money to hire a tractor or a field attendant. There is also the livestock to think of. The livestock also presents a problem as I told you earlier. My son tries to help but he is torn between looking after the livestock, having to find the lost or sick livestock, and having to come and check on us here at home. (CG23)

Many caregivers mentioned that their mobility was restricted by caregiving responsibilities. It seems that the situation of caregivers is worsened by taking on the role of caregiving, as sometimes it meant that they had to forego those activities which sustained them, as the extended family was not always available to buffer such effects.

Routine Tasks: Obvious, Mundane, Difficult

It was quite difficult to get a detailed breakdown of the chores caregivers performed for the elderly person they were taking care of. The tasks were described as simple and routine. Yet, at the same time, although often without complaining, the caregivers verbalized that they accomplished these tasks with difficulty. This caregiver noted:

> Help is just giving her water to drink, bathing her...isn't that help? Yes, we cook a bit of food, just helping mum. My sister also helps me by bringing something, I also buy this and that to help her and she helps me, too. However, we do this with great difficulty. You see, when people have their own homes, it is really difficult. For me it is even more difficult, because I have a handicapped son here as well. He was involved in a car accident, so I think his brain was messed up. Following this incident, after his father's death in 1994, he sustained a fracture during the New Year of 1995. Now he is just a handicapped person and only walks on crutches. So now I am concurrently taking care of the two of them, and I am just not able to look after both of them [she raises her voice to emphasize this.] Yes, I guess you could say I am not handling the situation well. (CG16)

The difficulties faced by this caregiver were multiple. She faced role strain as she had to take care of both her handicapped son and her mother. The context under which caregiving was done was also not easy. The pit latrine had collapsed and she did not have financial resources to build another one. She lacked resources because she was a widow. She also suffered some losses of her animal stock and crops due to prolonged caregiving of her late husband. Family remittances from her children were irregular.

Another caregiver described her chores for the neighbor she was taking care of as follows:

> I handle that old woman's dirty things (spits), I launder her blankets which are full of discharges from her bedsores, and I also launder her dressings (spits again). There are no gloves, the gloves are in tatters. Her sister came to help out and used all the gloves. (CG10)

Another caregiver explained how tired she felt at the end of the day due to the demands of household chores like cleaning, laundering and cooking special meals for her husband, as well as giving him his insulin medications:

> I try to do the best I can. When bedtime comes, I can barely breathe. I really try. You see, I am not well, my child. I have pain in both knees. I am really not handling the situation well. If you can only see, when time comes to knock off here I feel like I could cry, so absolutely tired. (CG06)

The dissonance between the caregivers' experiences of taking care of an elderly relative and their description of the situation, as well as the poverty surrounding them, led this researcher to coin the term "silent endurance." The definition of the situation was constructed in terms of meanings that were more consonant with the lived experiences.

Silent Endurance

Silent endurance constituted the ultimate paradox: caregiving was described as "just doing tasks," and yet these tasks were highly complex and difficult. These caregivers did not complain. They simply acknowledged the difficulty, if at all, in a stoic, matter of fact manner, usually devoid of emotion. Despite the silence, there was a palpable sense of despair associated with what they were doing. This was particularly true in the way they described their experiences, often completely devoid of emotion. They mentioned completely without affect, for example, how their relative was not on treatment because there was no transportation to the clinic. Others might describe in the same tone of voice how they were unable to feed their parent that day. There seemed to be no expectation that things would or could improve. When I asked one of the caregivers if caregiving had made any difference in her life, she said: "It has not made much difference because I guess I have just given up (keitlhobogile), because I see how my relatives have just left everything to me." (CG17) Perhaps in this resignation can be seem the roots of their thoughts regarding the future.

Religion and the Future

When asked about the future, many caregivers had little to say. Some seemed puzzled by the question. Others dismissed the possibility of change:

> I know that this is our life. We will always live that way, as you heard me explain that we do not see anything likely to change. We always give our parent what little life that we have received. (CG10)

Some mentioned that they left the future in the hands of the Lord. Religion seemed to play an important role in their belief system. Some viewed their suffering as the Lord's will.

Cultural Borderlands

Anthropologist Rosaldo (1989) used the term cultural borderlands, coined originally by Gloria Anzaldua (1987), to refer to the overlapping zones of difference and similarity within and between cultures. I use the term in this study to reflect such differences and similarities which existed among families in this study, and to show the impact of social change on culture and caregiving in Botswana. The normative cultural expectation that the elderly person should be taken care of by their eldest daughter or elderly relatives is continually being challenged and renegotiated in ideological practice. In practice, it is defended orally and in real life situations as family caregivers and their families live with the conflict and experience of taking care of the elderly person.

The conception of culture as unique and static has the limitation of emphasizing shared patterns at the expense of processes of change and internal inconsistencies, contradictions and conflicts (Rosaldo, 1989). Indeed, the families of the caregivers in this study illustrated that although there was an overall unifying national culture, there were variations as the culture undergoes changes. The borderlands that emanate from the overlapping of the contexts of families, in spite of the concomitant tensions and conflicts, are part of the mundane practices of everyday life (Rosaldo, 1989). Indeed, the family conflicts, in which the caregivers were involved, reflect this as I will explain later in this section.

The variation in the culture does not, as might be suggested, depict the falling apart of the culture. It is, rather, part of the process of maintaining and transforming a tradition in the face of overwhelming social change. "Such borderlands should be regarded not as analytically empty transitional zones, but as sites of creative cultural production that require investigation" (Rosaldo, 1989, p. 208). Culture is tenuous and changes over time. As it changes, certain roles change and are played out differently from the traditional ones. Hence society may be unable to sustain certain cultural expectations in the face of social change.

The concept of collective caregiving seemed to have undergone a series of transformations as it was shaped by the social changes and contextual circumstances like rural to urban migration and poverty. There was a continuum in the family structures which ranged from a collectivist system to an individualistic system, with a lot of variation in between. The borderland families also depicted those families in transition who fell between the collective and individual family systems. Some families seemed to be in transition from the traditional family to the nuclear family both in their structures and functions.

Family Caregiving Systems

Family Structures

In order to understand the two types of caregiving systems that evolved from the data, a description of the various families of the family caregivers that participated in the study is in order. The families comprised both nuclear and multi generational families. In the rural areas, three generation families lived together in one household. Multi generational families comprised the elderly relative, her/his children, grandchildren and great grandchildren, all living together in one household or homestead comprising several huts and sometimes houses. In these rural settings, the caregiver was frequently the head of the household, female, and elderly herself.

In the urban areas, nuclear families were more common. There were a few multi generational families, but smaller in size than those found in the rural areas. The urban multi generational families comprised the elderly relative, her/his children or child, and grandchildren; one family in the study also had great grandchildren. The biggest challenge for multi generational households in the urban area was coping with a lack of space. The situation of overcrowding was made even worse when relatives visited from the rural area, often to see the elderly relative.

In urban areas, middle-aged caregivers lived with the elderly relative while taking care of their children and, in some instances, while providing child care to grandchildren so that their mothers could work. Spouses who were taking care of an elderly husband in both urban and rural areas often had smaller, nuclear families. Grown children had moved away from their families of origin and set up their own homes in other parts of the country. In Botswana, as in many other areas of the globe, the role of family caregiving has increasingly shifted from multi generational families to the nuclear family (Apt, 1993).

Table 4-1

Living Arrangements of Caregivers

	Living with Elder	Living Away from Elder
Married	8	2
Not Married	13	1
TOTALS	21	3

Living Arrangements

Most of the family caregivers in this study (N=21) resided with their elderly relatives. Co-residence with a child sometimes seemed to have preceded caregiving, e.g., if the elder person's mud hut had collapsed in a storm. In one instance the elder person had come to live with a widowed daughter in order to support her through her grief, then fell ill. Otherwise, it seems that an illness typically precipitated co-residence.

Although most caregivers resided with their elderly relatives, three caregivers resided in their own homes and rendered care to an elderly relative who resided in his or her own household. The latter was usually within walking distance of the caregiver's home.

Two of the non-resident caregivers were married daughters who had homes of their own. One took care of her hemiplegic mother who lived alone. She also had a sick elderly husband, a full time job, and children to take care of. At one point, she had moved in with her mother, but this caused marital problems when her in-laws accused her of neglecting her husband. Because her in-laws threatened to move her husband from his home, she was forced to move back.

The other married caregiver mentioned that her husband worked in another part of the country and that, consequently, she was unable to visit him there frequently because of her responsibilities towards her mother. Instead, her husband was the one who visited whenever he had days off. These two caregivers were faced with competing demands of caring for both parents and husbands. Another non-resident caregiver was a neighbor who, although not married, was a single mother with children of her own. She mentioned how her income generating activities had suffered as a result of taking care of her elderly neighbor.

Married Caregivers

The situation of those caregivers who were married and taking care of an elderly parent posed problems different from those faced by unmarried or widowed caregivers. Married female caregivers did not usually stay with their mothers. They typically were called upon to give care in those cases in which they were the only daughter of an elderly parent or, when other siblings were available but were unwilling to provide the care. One caregiver moved in with her grandmother as there was no one to take care of her following the sudden death of her mother. She was married and lived in another village, but her sister, who lived in the same village as the grandmother, refused to provide care.

Although the families were comprised of many individuals, family members often lived far from one another, having traveled to obtain a job. Therefore, the conditions that defined the individual family caregiving systems varied widely in terms of the number of children, their feelings of obligation towards caring for the elderly relative, their living arrangements, other family roles and responsibilities, the location of family members, and their proximity to the elderly caregiver. However, proximity was not always an indication or predictor that a family member would assume care of the elderly relative.

The study revealed two main types of family caregiving systems: individuals who were giving care in collaboration with other family members and those who were giving care alone in spite of the existence of other family members within close proximity. In between these two systems were many hybrids, so that most appeared to be somewhere on a continuum.

Collaborative Family Caregiving

In this system, an elderly relative was taken care of by more than one relative. Family members were able to collaborate in caring for the elderly relative within one large household or among different households. Collaboration is multidimensional with many aspects of the care being done as a kind of team effort. The dimensions that were shared included family caregiving tasks like fetching water, tilling the land for subsistence farming, providing financial support, and turning out in times of crisis.

Some family members collaborated in the care of the elderly relative by rotating the elderly relative from the home of one sibling to the other. In this arrangement, the elderly relative spent a few weeks at a time in the home of each child. In some instances, family members who were not employed full time would move to the city to assist a family caregiver who was working full time.

Individual Caregiving

Individual caregiving occurred when only one person in a family assumed the responsibility of caring of the elderly person, despite the demands this placed on that individual. This occurred under many varied circumstances. Individual caregiving occurred in those families where the elderly person had no children, had one child, had no surviving relatives other than the caregiver. In some cases, it was evident in those families where there were many siblings. Individual caregiving occurred in both rural and urban areas. One caregiver who was solely taking care of her husband noted: "As far as this illness is concerned, I am alone, my parents are not involved, I am just alone." (CG08)

Despite evidence to the contrary, individual caregivers were quick to note that caregiving was meant to be a shared endeavor. They poignantly noted that giving care by themselves was a very difficult thing for them. It was clearly viewed as a departure from the cultural norm, and many caregivers echoed their disappointment with their situation. One frequently heard such things as: "We are three children, but these other two do not care for him. I am struggling alone. (Ke wa wa fela ka ene ke le nosi.)" (CG16)

Evolving Family Roles

Although caregiving is traditionally a female role, two of the caregivers in the sample were men. One was taking care of his ailing mother, with the assistance of her sister who was also very sickly. When he spoke of the difficulties related to his caregiving activities, he mentioned that men did not understand how to provide care like women.

> The only thing is that I am a man; if I were a women, there would not be much of a problem. You see, a man cannot take care like a woman. You see, we usually leave caregiving to women, but seeing we are doing this together, we do it the female way. (CG05)

This attitude tended to reify the notion that women and men's nature was immutable and distinct. In such cases, caregiving by women was viewed as normative and the men's performance measured in comparison to it. Unfortunately, this strategy understates both the diversity within gender and the similarities between men and women (Crawford and Maracek, 1989).

Gender Roles

Boy Child vs. Girl Child

Several caregivers subscribed to the belief that the girl child contributed more to the caregiving situation than the boy child. A caregiver who was looking after her diabetic husband relied on her two sons to read the insulin dose for her. However, she expressed anxiety over having to rely on her boy children who, she felt, were less reliable than the girls:

> Even as I am struggling like this, no, the boys are absolutely useless. Yes, as soon as they wake up, all they do is to just run around in..in..in..the streets. They are of no help at all. (CG06)

When asked if they were different from girls, she answered:

> Yes, they are different from girls. Because a girl, even if I am present in the home here, she will be also present. So much that sometimes, because I cannot see well in the eyes, when the sun sets, I keep on anxiously asking myself where have they gone? Who will pour the medicines for me into the syringes? I am not able to measure them properly. (CG06)

Another caregiver who had left work in order to take care of her mother, mentioned that she relied on remittances from her children. However, she mentioned that the girls were more reliable than the boy. She said that, in order to obtain some money from her son, she had to catch him at the beginning of the month before he had spent his entire earnings:

> I only manage to get some financial help from the one son who works in Lobatse if I get to him before he spends his wages. You know how they are, these boy children. (CG09)

Although some participants seemed to think that girl children were more reliable than boy children in terms of giving/rendering help, in a few instances, boy children were said to be more helpful than the girls. A caregiver who was taking care of both parents acknowledged and praised her son for being very helpful. She mentioned that her son had provided all the clothing her parents owned. This same son had a truck and often brought the parents firewood. In this household, the caregiver sang the praises of the youngest daughter also who took care of the mother and grandparents on days when the mother was sick.

In another family, the caregiver mentioned that her older son was very helpful around the house whenever he visited. However, he did not visit frequently since he worked in the city. The caregiver lived with a younger son who also helped her a great deal with caregiving tasks like bathing her husband and taking him for walks. So in actual practice, depending on the circumstances, both boy and girl children helped with both caregiving tasks and financial assistance.

Although a majority of participants seemed to think that girl children were more reliable than boy children, observation did not substantiate this commonly held notion. Rather, the kind of help they rendered was merely different and depended on their location, occupation and resources.

Normative Expectations of Elder Care

In this section, an effort is made to give voice to participants regarding who they think *should* be taking care of an elderly relative. This is then later contrasted with the reactions of the participants to their lack of fulfilment of these expectations. Cultural expectations or norms of who should take care of the elderly varied according to gender and age. One caregiver who was taking care of her father explained:

> An elderly person like my dad, must be taken care of by his eldest son because he is a man. But, because his male children are deceased, I feel it is right that I should take care of him.

Three caregivers mentioned that an elderly person *should* be taken care of by her/his eldest daughter. Two younger caregivers said older relatives should take care of the elderly person.

> Taking care of an elderly person should be done by someone closer to her age, but fit and able. (CG09)

However, when asked what would happen if that person was unavailable, this same caregiver said: "Well who else...I guess we have no choice but to do it ourselves." In other words, in some instances, it appeared that caregiving was done by default and out of a sense of obligation. A male caregiver who was taking care of his mother mentioned that it was primarily his sister's responsibility and that he was only doing it because his sister was sick. He also mentioned that women gave better care than men. A male neighbor who was assisting with the care of his male neighbor, mentioned that a man sometimes needed other men to take care of him, as women were not strong enough.

Although some siblings were not fulfilling their filial obligations, one caregiver noted that reasons for fulfilment of such an obligation should be voluntary:

> Hmm...(shakes her head). I cannot say that they should help with anything. You see she....a parent is a parent, your parent is your parent. You should be the one to decide how you can offer help. If the child of a woman does not wish to help with anything...like now I have my sister here, I cannot say to her...absolutely not. Sometimes when I plead with her and say, mother does not have any soap, she turns around and tells me that her there is no soap in her house either. So, you cannot afford to talk to people like that. I cannot say they should help with anything. It is up to you, the depth of your heart, what your parent means to you as an individual (go tswa mo go wena, boteng jwa pelo ya gago gore wena motsadi wa gago, o mmona e le eng mo go wena). (CG18)

Unfulfilled Expectations

Batswana have certain openly stated normative cultural expectations of each other, especially of kin. Families expect that family members will take care of their own, that men and women will take care of their spouses, that children will take care of their parents, and that siblings will provide assistance when needed. Thus, given the collective kin ideology that is so basic to Batswana culture, caregivers, it was learned, were deeply disappointed when this cultural expectation went unfulfilled. As one caregiver noted in relation to her children:

> You know that children today do not take care of their parents. I really should not be suffering like this because I have big children. I am suffering because children nowadays do not take care of their parents. Even if he or she promises you that this month they will give you some money, when you get to their place, they break their promise, and give excuses as to what they have done with their money. (CG09)

Another caregiver, who was taking care of her husband, shared that she had called her daughter who was working 430 kilometers away and asked her to come and help her. She went on to note:

> Recently, I was really burdened...so much so that I called one daughter who works in X town. I told her to resign from work so that she could come and help me. I told her that I was truly failing. She told me that she had purchased furniture and other things and asked who was going to pay for all these things if she stopped working. So that really failed. (CG06)

Still another caregiver expressed disappointment about a sister who was not participating in the care of her grandmother:

> My sister is in this village now, but still she did not even come to check on her this morning. Sometimes she comes late at night, and she would then inquire what I have cooked. She would then eat and go home to her place. She won't even ask her children to go and fetch water and cook for their grandmother, or come by herself to do her own mother's laundry. (CG17)

Caregivers were, however, aware of the social changes which made it difficult for children to fulfill their expected role, as this family caregiver noted in response to being questioned about the extent of family help from children.

> Really there isn't, I can say that there isn't any help because a person is helped by her or his children. Now, when the children also have offspring of their own who attend schools, then I have problems. You see children cannot help you like a parent. Like now as they are in towns there, they are in their own homes there. Sometimes three months elapse before they give me anything. I really have problems too because even my husband whom I had been with, ...I took care of him for eleven years. Even if one had animal livestock before, can it still be there? It got finished. Even if tomorrow there was a registration of cattle, truly I do not even have a cow or a goat or anything, I am just a person with nothing. (CG15)

Another family caregiver noted the diminishing role of the extended family, especially children:

> It is difficult. It is very difficult. As it is now, we do have children though. But the children...they are grown up. They are in their own homes. It is difficult for them to come and attend to us in our own homes. (CG07)

Consequences of Unfulfilled Expectations: Family Conflict

In some families, family caregiving of the elderly person was a contentious feature of cultural ideology. The changing social context created tensions within normal relationships in families which led to family conflict related to caregiving. This was more common in those families where a caregiving burden fell on one individual in spite of the presence of many other family members. A number of the participants in this study indicated that they were having some problems with another member of the family over their lack of participation in caregiving activities. Most often, the unwilling relative tended to be a sibling, cousin, or in some instances, an elderly relative who refused to contribute.

Both brothers and sisters, as well as other male and female relatives, contributed to the conflict. It seemed that all age groups became involved in the conflict when it arose. While caregiving is predominantly perceived as the responsibility of women, male caregivers were quite outspoken in their expectation that their siblings contribute to the caregiving activities. Grandchildren also took a position in the conflict. Grandchildren, reacting to what they saw as an inequitable caregiving situation, sometimes refused to participate in the caregiving chores like taking the food to the grandmother's house. Grandchildren withdrew, and also questioned why other family members did not participate, especially when those family members had better resources like a car for transporting food. In one instance, conflict was anticipated because several male cousins refused to participate in the care of a dying relative. The angry caregiver explained:

> They do not help in any way, which means that if in the near future, God decides to do his will as far as my dad is concerned, I anticipate that they would give me a hard time. (Pauses). The way I see things, because I am taking care of him, I would not also agree that after struggling with dad, then have them (cousins) come here tomorrow to come and take him away from me. Did they ever prove their worth while he was still alive? I will refuse. I shall just struggle with him alone. However, I shall be able to...(pauses) to bury him by myself. (CG02)

Dynamics of Family Conflict

Conflict was multidimensional, and occurred among various parties. In some instances, it occurred directly between the caregiver or caregivers and the elderly relative. One blind elderly woman mentioned that she was grossly neglected by her children and grandchildren. Upon hearing that this nurse researcher was doing a study on family caregiving of the elderly, she said:

> There is no care, no care at all. If you walk into my room, it is awful. It smells of nothing but urine. I have long been requesting that they go and buy me some firewood so that I can warm up some water and take a bath. I even gave them one pula for the firewood. (CR10)

After she said this, the daughters and grandchildren blamed her for openly airing her dirty linen in front of strangers. However, the daughters simply walked away after reprimanding her for telling such stories to strangers.

Some caregivers were aware of the conflict going on in their families and acknowledged it as well as its impact on the care of the elderly relative. As one caregiver said: "I mean that is our major problem, conflict over the care of our mother." Some caregivers found the whole thing of family conflict baffling and they just did not understand the behavior of some of their family members. "I do not understand the minds of those children. [ha ke tlhaloganye di tlhaloganyo tsa bana bale"]. (CG18)

Conflict seemed to occur frequently over anticipated help, caregiving tasks, family remittances from those in urban areas, and care recipient's income, e.g., their pension. One caregiver mentioned that a relative who was managing her mother's pension was financially abusing her mother, and this led to a degree of tension in this family.

These findings underscore similar findings of Strawbridge and Wallhagen (1991) on family conflict. In their study, they found that brothers and sisters were about equal in being the major source of conflict. Family caregivers were just as upset when family help was not forthcoming from either gender. They also were baffled by the behavior of their family siblings.

Complex Conflicted Families

Conflict took on another dimension where caregiving occurred in complex family situations, for example, when an elderly mother had children from two different marriages or where an elderly husband in a polygamous family needed care. In the latter case, an elderly husband was living with his third wife in the city. This wife, together with his sister and the daughter from the first marriage were all taking care of him. The doctor had transferred this man to a hospital in another town where his first wife was. The children, who had the resources to move their father, were very reluctant to do so because the first wife was no longer interested in him. The children did not recognize the youngest wife and were threatening to evict her from the urban home following the transfer of their father to another hospital. Under such circumstances, the elderly person usually suffered. In this case, his dressing, which needed to be changed daily, had not been changed because no one seemed willing to approve the transfer and transportation to the clinic was unavailable.

In another family where the children from different marriages were in conflict over the care of their mother, the elderly mother, hemiplegic and incontinent, was abandoned. Yet another caregiver was in conflict with her sister and elderly relatives who were not contributing to the care of her grandmother.

Range of Variation

Some families did not experience conflict and helped each other with caregiving tasks. Some caregivers, moreover, did not expect any help from family members as they mentioned that they did not have any siblings who were still alive. In these cases, there did not seem to be much bitterness over the lack of help. In other families, it appeared that one person was shouldering most of the responsibilities. However, this did not seem to cause any feelings of resentment or conflict as the caregivers appeared to have resigned themselves to being the sole care provider and did not expect any help from their siblings or other relatives.

Conflict Resolution

Conflict resolution in Setswana culture is a group process which involves a meeting with other parties where elderly people are involved. The people involved in the conflict are also present at this meeting. The grieved party presents her/his case to the members of the family who are present, and the case is then discussed at length. After both parties are listened to, the elderly people present make a decision about who is at fault and what course of action should be taken. Even sole caregivers did not have the authority to make decisions independently, in spite of their apparent independence and isolation. In the event of a problem or conflict, family members were almost always called and the problem or dispute discussed and settled. One elderly man who was looking after his father alone indicated he was about to call a meeting with his two brothers who were not participating in any way in the care of their father.

> Right now I am thinking of looking for them.... I want to look for them and have them come here. Then I will call my uncle so that he can see

> these children (meaning his brothers). Then I will ask them ...seeing they have just abandoned dad...what are they thinking about him? I will ask them, what do you think about him? (CG16)

Another caregiver expressed frustration with her own brother as well as step brothers and sisters who, although they had good educations and jobs, were not participating in the care of their mother. They had moved their mother back to her home where she lived alone; shortly thereafter her hired helper abandoned her. She was planning on having a meeting with them at Christmas in the presence of their elderly relatives to inform them of her plans regarding the care of their mother. She had decided she was not going to be moving up and down between her home and her mother's and was, therefore, going to move her mother back to her home.

In Botswana there is a pervasive belief in male dominance; hence, authority is usually vested in men. The caregiver may have authority over day to day activities, but lack final authority in regards to the person they are caring for. The ultimate authority within a family usually lies with a male figure who may be a spouse (or uncle in the case of a female headed household). Traditionally, it is said that a "woman is a child of a man," referring to the fact that under customary law, women always have guardians. This, however, varies from tribe to tribe, and quite often is uncertain (Molokomme, 1993). Hence, in Batswana culture, there is invariably a need for a male figure to be present at the conflict resolution meetings. One caregiver's concern over possible conflict with her male cousins over her father's burial exemplifies this. The power relations inherent in female- headed caregiving families mirror the broader social contexts in which women are subordinate to men.

Some family caregivers had substitute kin or virtual kin because they either lacked blood kin or their kin were not participating in the care of their elderly relatives. These caregivers, if they were on welfare, consulted with the City Council social welfare councils on issues that would probably have been resolved in a family meeting. In a few instances, in other words, the family conflict management system had been replaced by a bureaucratic, non-traditional system.

Family dynamics and the type of authority which the caregiver had dictated the course of action taken by a caregiver. However, if a quick decision was required, this was usually made before consultation. For example, a decision may be made to take an elderly person to the doctor while the rest of the children are being summoned. The children would come later, and together with other elder relatives, decide on a significant course of action following the initial intervention by those relatives who were at hand.

Group decisions were not always or necessarily in the best interest of the care recipient and caregiver. After a meeting of the children of one woman who had had a stroke, her children decided to move her from her daughter's house to her own home to be looked after by a hired worker. The worker soon absconded, leaving this elderly woman alone. The daughter who had been taking care of her was upset and exclaimed: "I vow that from today, I will never take my mother back to my place. I will just leave her in her house. People will ridicule all of us, as you can see that among our relatives no one cares for her."

However, in some instances, the caregiver reluctantly followed such a course of action to avoid conflict. Conflict resolution seems often to be a metaphor for examination of the power structure of Tswana society, and whether, how, and by whom the dispute should be resolved.

Abandonment

Abandonment featured as a very prominent theme in the research on caregiving. Properties of abandonment illustrated varying aspects of unfulfilled cultural expectations. There was abandonment of the culture, of the elder, and of the caregiver by both kin and the health care delivery system. Social change, as reflected in differences in values, was the underlying condition inherent in all cases of abandonment.

Rural Versus Urban Values

Differences in attitude and behavior often manifested themselves according to the family members physical location. Siblings, and some caregivers in urban areas, expressed different options for managing the caregiving experience than their rural counterparts. City-based relatives, finding themselves unable to take care of their elderly relatives, sometimes resorted to non-traditional caregiving styles. One of the caregivers interviewed expressed a desire to hire someone to care for her elderly parent, if only she had the financial means. In fact, some urban-based siblings did hire help for their elderly mother who lived in a village. In this particular case, a different sibling who resided in the village felt strongly that their mother really needed to be taken care of by her children, especially where intimate care like bathing was concerned. To her, the hiring of help constituted a departure from the traditional ways of doing things. This departure from tradition implied to some an abandonment of culture.

Abandonment of the Caregiver

Individual caregivers often felt abandoned by their family members. Tradition dictated that this was an undertaking to be shared by many people and, when this did not occur, began to fester. In some instances, the abandonment was accompanied by expressions of guilt. In other cases, relatives expressed no feeling of guilt. In some of the situations under investigation, the abandonment of the elder seemed to serve as a catalyst which propelled the caregiving response.

Abandonment of an Elder

Elderly people were abandoned by their family caregivers or members of the family under certain conditions. Caregivers abandoned the elderly in order to go to work and earn a living, or go to the fields and plough since their livelihood was related directly to subsistence farming. Under such circumstances, the elderly was usually left alone or relied on neighbors and other extended family members to look after them while the caregiver was temporarily away. However, in some cases, the elderly person was left alone for some hours. For some caregivers, abandoning the sick family member in order to go to work was a way of coping with competing demands. Yet, some caregivers agonized over doing this and expressed a sense of guilt over this decision.

> When I am not here and he is alone, I think he becomes preoccupied with many thoughts. He ponders...perhaps he thinks that I have abandoned him... (CG16)

One helper who was hired to look after an elderly person abandoned that elderly person after deciding they could not cope with the caregiving tasks. Care of this elderly person involved intimate tasks which, culturally speaking, should be performed by immediate family members.

Seven family members argued that because other family members were not contributing to the caregiving situation in any way, this constituted abandonment. In these instances, the family members did not participate in the care of the elderly person in any way. This was true even when they lived in the same general vicinity as the elderly person.

> I would find it difficult to abandon my parent like my sister and aunt have done. Even if I am unable to take care of her because I am ill...on days when I am well, I will do the best I can, and on those days when I am unwell, I guess I cannot. I am disappointed that no one is helping me when there are people who should be helping me.

Some lived in the same village as the elderly person, yet, went for months at a time before offering to help:

> Yes ma'am, the ones who are here are women. One is M..., married to the principal. She is a teacher at...school. But this sister, she is just somebody who just does not care. She does not even...she can go for months without even setting foot in her mother's place. But her family comprises ordinary people who are not sick, but are quite well. Yet, she is not able to help me with anything, not even to do anything. As you can see, the Family Welfare Educator brought you to me; if she had taken you to my sister, maybe she wouldn't even have spoken with you. I mean, I just do not understand her thinking. When she gets angry, she really gets angry. (CG18)

Temporary abandonment was used by some family caregivers as a survival strategy. In their minds, this was necessary and appropriate given the non-participatory nature of other relatives to the caregiving situation. Temporary abandonment was also used by some caregivers who had reached the limit of their tolerance. As one caregiver explained in reference to her bed-ridden, hemiplegic mother:

> Recently, I decided I needed to withdraw. I stayed here without going there...to mother's place. She went a whole week without being bathed. When I went there, I found the place filthy. I thought that maybe she had died. (CG18)

Abandonment of Culture

There was also an occasional shift in values within and among family members. The siblings who lived in urban areas tended to take on new values that were different from the traditional ones. Urbanization brought with it the adoption of western values. Some caregivers who remained in the rural areas felt alienated by those siblings who abandoned traditional cultural ways for western ways. Speaking in reference to the difference among her siblings, one caregiver noted:

> Now these other ones, these white ones, you see if you live in Gaborone, you become a white person. When they come, they bring things called biscuits and drinks. Really as if though they were treating mother like a small child in a creche. (CG18)

This rural caregiver was implying that it would have been more helpful to have brought solid food rather than junk food. Sodas and cookies tended to give their parent diarrhoea, which only added to the work of the caregiver.

Education and sophistication brought with it an occasional shift in attitudes towards food. One caregiver thought this constituted losing touch with the cultural importance of certain foods. She lamented the loss of this cultural connection and also the accompanying implications of having to maintain her mother on a western diet.

> My mother likes rice. She likes white people's food. She likes rice with all its trimmings. If you cook rice today, she expects that the next day you should cook macaroni, because she used to be a teacher and used to eat those things. So now, these are the things that she wants. When I cook sorghum (bogobe) and give her the sorghum, she refuses. So, I am not really asking any of my relatives to bring anything, because I just force mother to eat the sorghum. (CG18)

Some urban-based families hired a helper to assist an elderly relative who was still residing in their home in the rural area, as they felt that they were unable to render care to someone so far away. On occasion, these hired helpers abandoned the elderly person, often not even bothering to communicate their intentions to leave. This was particularly true in those cases in which the elderly person was incontinent. Culturally intimate care was thought of as work that was not appropriate for non-family members. It was interesting to note that the rural-based woman who had been hired to bathe this woman also left the job, ostensibly because she felt it was inappropriate for her to take care of this woman alone when her own children were available.

Abandonment of Elder by Kin

Male, female, young, and old family members abandoned the elderly on an equal basis. One caregiver seemed confused by the changing values among her siblings. She questioned if the abandonment of their mother was a consequence of attaining an education and an urban lifestyle:

> Seeing how it was mum who has educated my brothers and sisters like this, sometimes I really shudder in awe. I question whether if mum had educated me like she has educated them, would I not care about her? Like now they live in big houses in the city, which means that they could at least take mother sometime and go and stay with her. But they do not even care to come and see her or to come and stay with her. (CG18)

Abandonment of Elder by Health Care Delivery System

In their interactions with the health care delivery system, some caregivers felt alienated and abandoned by the health care professionals. This was very disappointing to the caregivers who looked upon health professionals as integral to their caregiving efforts.

Reactions to this form of abandonment were varied. In those instances where it invoked strong feelings, there was often a clear conflict with the health care system. Some of the families expressed resentment towards the health care system feeling that they had been neglected deliberately because their relatives were old.

Boundaries of Culturally Acceptable Options and Resources

Both families and the government offered families some help. However, some of the assistance was accepted and some was turned down as unacceptable in spite of the family caregivers' plight.

Embarrassing Options

Although some governmental support was offered to people who were classified officially as destitute, the stigma dissuaded many to apply. Three caregivers had considered registering an elderly care recipient as destitute, yet hesitated to do so because of embarrassment.

In another instance, an elderly hemiplegic was registered by social workers as destitute so that she might obtain a wheelchair. Her daughter requested that her name be removed for fear of upsetting other siblings. Indeed, when the other sister found out, she was very angry and demanded that her mother's name be taken off the list. This underscores the finding by Letsie (1993) that, destitute status compromised people's dignity and self-esteem, and that people avoided this status as they did not wish to be buried as paupers.

Other family caregivers seemed to think that it was better to struggle with very little resources rather than register their elderly relative as destitute. They believed that doing so was tantamount to abandonment of the elderly relative. Some family caregivers acknowledged that they could use extra help from the destitute program, but found the embarrassment more than they could bear:

> Really we were now thinking that, if it was not for her children, we would register mom as destitute. But we keep hesitating, thinking, will people not laugh at us? We think...you find us here with our mum, then how can she be registered as a destitute when we have her here. This makes us feel very embarrassed. Then we think that, we cannot be with a person like this, when she is our parent, then register her as a destitute, why can she not eat whatever we are eating? I mean it is just like that. (CG15)

Appropriate Versus Inappropriate Family Help

Family social support was viewed as appropriate or inappropriate, depending upon the needs of the individual caregiver. In some cases, merely visiting the elderly person was viewed as sufficient while in other cases, nothing short of financial contributions was deemed appropriate. One caregiver succinctly described this attitude. When asked about other family member's contributions, she noted:

> Well, not really, you see the extended family's help is to just coming and checking in on how mother is doing, asking how she is doing. That is their help, nothing else beyond that. There is really nothing, to say otherwise would be to not speak the truth. They do come to see her a lot, but there is no help, no help. Because if help was available, people would acknowledge that I have mother here and that I am struggling. They would acknowledge that my pit latrine has collapsed. They would be thinking of ways that they could help me, yet there is no help. (CG14)

Indeed, observational data validated the caregiver's feelings in this instance; various relatives walked in and out of the hut to greet the elderly woman where she was resting.

Although this particular caregiver did not think that this kind of support was adequate, it is, nonetheless, a very important aspect of collective life in Setswana culture.

In other situations, caregivers complained that hardly anyone came to visit the elderly person:

> The relatives do not come and visit and this causes her (elder) concern. I have sometimes urged them to come and see her, but they are very reluctant. (CG22)

This underscores the finding that the effectiveness of social support depends on a number of conditions and, therefore, needs to fit appropriately with the types of problems confronting the individuals (Pearlin, Aneshensel, Mullan & Whitlatch, 1995).

Intimate Care

Caregivers seemed very clear about the distinction between general care and intimate care. In homes where there was hired help, caregivers believed that intimate care remained the sole responsibility of family members. When asked to consider this possibility, the caregivers voiced strong opposition to it, claiming that this kind of care was best offered by one's children. Some caregivers, especially in urban areas, used hired help in their homes. In these instances, the caregivers always felt compelled to explain that the hired person was not involved in the intimate care of the elderly person. Intimate care was exclusively done by members of the family.

Cultural Taboos

One male caregiver mentioned that executing certain tasks was inherently difficult for him by virtue of his gender. For example, he found it difficult to launder underwear for his mother. Ideally, in the Setswana culture, one should wash one's own underwear unless one is sick. However, women can launder men's underwear if necessary, while a man cannot launder his own mother's underwear. A mother also can always launder a son's underwear. Regardless, if this task must be done, it is considered intimate and should be done by someone close to the person. In the absence of laundromats and washing machines, available only in the rural area, laundry is done by hand. This poses a problem for family caregivers who are sons. For these men, hands on care such as bathing, dressing, and toileting, are to be avoided if at all possible since they are viewed as inappropriate or even taboo (Montgomery, 1992).

One caregiver who was taking care of her father expressed uneasiness over bathing her father. However, she mentioned that because her male cousins were not participating in his care, she was forced to bathe him herself. Differences in the tasks that sons and daughters render were not been reported by husbands and wives who assume the caregiving role (Montgomery and Borgatta, 1985).

Grandchildren's Assistance

The amount of resources available to the caregiver guided the strategies which were adopted by various family caregivers. One married caregiver who was, herself, an only daughter, was unable to be with her mother all the time, so she voluntarily proposed that her daughter (an only child) go and live with her mother. The daughter, who was 13, was able to run errands for the grandmother after school. She helped the grandmother with small chores like fetching water from the tap, and by assisting in her small business.

Some caregivers did not have financial resources to mobilize, especially in individual caregiving systems. Two of the married caregivers explained how they instructed their children to go and live with a grandmother, so that they could assist the elderly person with certain chores or errands after school.

> When I realized that my mother was sick, I decided that my child should attend school at my parent's place, so that when she comes from school, she can at least fetch water for them, because that was a difficult task for mother. (CG17)

This strategy was not used commonly since most parents preferred having their children at home with them while they were still going to school. However, it did appear to be popular among caregivers who were old and needed help with caregiving of an elderly relative. Several caregivers specifically mentioned that they wished that they could have a grandchild who could live with them; however, they understood the parents wish to be with their own children. Several caregivers who had declined to move in with their children mentioned that they would have liked, nonetheless, to have had a grandchild who could help them with chores around the house.

Sense of Place/ Cherished Independence

Elderly caregivers seemed to cherish their sense of place. Assistance from children was quite welcome and customarily given in Setswana culture. However, when the grown children extended an invitation to the parents to come live with them elsewhere, the aged parents were reluctant. They were willing to accept help, but preferred that the help be given in such a way that they could remain at home. This caregiver explained her reticence:

> My daughter was saying that I should go and live with her, but the home, this thing called your own home, while you are still active, and still feel that you can at least sweep, you find that your heart refuses to abandon your own home and go and live there forever. (CG4B)

Another spouse caregiver spoke of how much she cherished her independence:

> Old people should be taken care of by their own eldest daughter. Although we are old like this, we still feel that to go and live with a child and a son-in-law in their home is difficult for us all. It is still...it is difficult for us. The children are there and they have good accommodation in Lobatse; they have even built a house. But it is still difficult for me to go and live there with a daughter and a son-in-law. I am still, my heart is still kicking (laughs). I am still able to do this and that...sweep in the house. I am still... now to go and live, it means to be a "just sit there only kind of person." Being waited upon...it is very difficult for me. Unless...if they could give me someone at least, a grandchild, but now the story of the grandchildren also... Her children are...they attend school, the eldest daughter does. (CG06)

The eventual introduction of a state-funded pension for old people may foster more economic independence for the elderly who are fairly well equipped to live independently.

Government Aid or Social Security

Caregivers had mixed feelings about the pension for aged people. They mentioned that, although the money was not much, it would at least be better than nothing. At the time of data collection, plans were in place to introduce this policy in October of 1996. Some caregivers stated that they were not aware of this proposed policy.

Range of Variation

These interviews suggest that different options were available to family caregivers. Depending upon people's situations and values, some of the options were viewed as demeaning while others merely did not address their needs. Some options were illustrative of cultural transitions and attempts at replacing the cultural collective ideology with something close to that. For example, for those caregivers who accepted welfare, in spite of the stigma attached to it, the welfare system served as a pillar of strength in times of need as they worked closely with the social workers.

Boundaries of Health Care Access

Caregiving of the elderly is inextricably linked to several salient issues: the poverty within which the families are situated, a culture that assumes that families care for their elderly when this is not necessarily the case, and a health delivery system that lacks home-based care for the elderly. With few outreach programs for the elderly, this age group often found itself without access to health care.

The lack of access to health care emerged as one of the biggest problems faced by caregivers. Many of the caregivers were taking care of frail elderly relatives who suffered from hypertension, diabetes mellitus, and joint pains, and who should be receiving on-going medication. Unfortunately, caregivers often mentioned that elderly relatives were not receiving treatment because the elder was not able to walk to the nearest clinic and had no access to alternate transportation.

Transportation

Quite often, lack of transportation was a major reason for the lack of access to health care. Five (21%) of the caregivers mentioned that the elderly person was not on any treatment, particularly the stroke patients, because they lacked a means to take them to the clinic. Some of the caregivers were able to find the means to hire transportation while others found this beyond their means. They described this situation with a sense of helplessness and despair.

> When my sister used to come, she used to take mother's treatment card and go and request treatment for her at the clinic. Now the nurses refuse and

> say that they do not know the person we are talking about. They insist that she should come to the clinic. That is why, when recently, the doctor spoke about a wheelchair, I said, maybe the wheelchair will help us because when she is unwell, we can push her in it and take her for her check-up. (CG18)

Other caregivers expressed similar sentiments, noting:

> It is sad that our society has no social welfare system, because if it existed, the relevant incumbents would be assisted with items like wheelchairs and whatever else they may need. This would make life much easier, we could wheel our relatives to the clinics, or just around for visits with the neighbors or walks. (CG23)

Although transportation to the clinic could sometimes be requested , many caregivers seemed unaware of this. In the rural areas, the clinic van was most often the cheapest transportation, usually costing no more than two pula. However, the van was frequently occupied and most clinics had only the one vehicle. Further, staffing posed yet another problem. Sometimes only a driver was sent out to pick up the patient when, in fact, an additional attendant would have been needed: "How can I lift my mother alone into the clinic vehicle?" (CG24)

Even those who could afford to hire a vehicle to take their elderly relative to the clinic mentioned that it was problematic finding people to assist with lifting the elderly person in and out of the vehicle.

> I have to hire a vehicle, and then get manpower to help him into the vehicle. Sometimes the Family Welfare Educator comes to visit, but now she has not been for some time. We do not know what the situation of the blood pressure is at the moment. I went to ask for his blood pressure tablets, using his clinic card, but they refused to supply them. They said the patient has to be checked before the next supply could be issued. (CG23)

> Now, she lives alone and I am unable to take her to the clinic. You see, if you do take her for her check up, it means that there must be people

> available to lift her. Like now, for months she has been talking about a check-up saying that there are some people who have promised to take her for her check-up. (CG18)

When asked if there were vehicles in the village or city that they could hire for the elderly relative, they mentioned that such vehicles were there, but it cost money to hire a vehicle. For most, it was money better spent on food and medicine than on transportation.

A few families had children who worked and lived away from home and owned vehicles. The family caregivers relied on such children to transport the elderly relative to the clinic. However, they also mentioned that such visits from children were sporadic and infrequent. Relying on such distant relatives for regular help was not possible.

One elderly man had been discharged from a hospital with instructions that he was to be taken to the nearest clinic daily for a change of dressings. A week later, he had not once been to the clinic. When the caregiver was reminded of the importance of changing the dressing, she replied that he was unable to walk and that there was no way they could have transported him to the clinic since she had no money to pay for a vehicle. Eventually, a clinic vehicle was dispatched to take him to the clinic for a change of dressing.

In the rural areas, the public transportation is not as developed and available as in the urban areas. In the city, for example, there was an ambulance service which was run by the City Council and charged a nominal fee. Such a service did not exist in the rural areas. In the city, too, there was a Sister from the Catholic church who paid visits to elderly people, particularly the destitute, to help them with chores in their homes. This

Sister quite often transported elderly relatives to the nearest clinic. Unfortunately, other than this Sister and the City Council, there were no other services available to assist family caregivers. This was slightly different for those elderly people living in the city who had been registered as destitute by their families. For them, transportation was provided free of charge by the City Council. The poor are the most affected by the transportation dilemma in Africa in terms of both the cost and their dependence on it for employment as well as to obtain services (Hope, 1997). This lack of money was an issue that identified by nearly every caregiver in this study.

Consultation Fee

Four family caregivers mentioned that they had not taken their elderly relatives to the clinic because they could not afford the consultation fee. While the Ministry of Health (MOH) has a policy that no one should ever be turned away for lack of funds and all preventive and promotive services should be free (Republic of Botswana, 1994), it seemed that there were inconsistencies in clinic charging practices. In the main hospitals, consultation and medication for chronic illnesses like hypertension was not paid for, as this was considered promotive health, whereas in some of the clinics, patients were expected to pay the two pula consultation fee. This was confusing to some caregivers.

Although some caregivers were themselves sick, they had not gone to the clinic for treatment because they lacked money to pay for the consultation fee:

> There is nothing which is better now. But, whenever I get some money, I go to the clinic when I do not feel well so that I can get treatment. Sometimes I do not get treatment and many days elapse, because I don't have any money and so can't be seen by the clinic staff. (CG04)

One woman would not take her mother to the clinic for blood pressure medication. She mentioned that she was afraid to do so as she had not yet paid back the consultation fee for her own consultation. When I insisted that she would not be turned away, she informed me that the nurse had written on her treatment card that she owed two pula. She also mentioned that the same nurse had not been very pleasant about it. It seems that everyone was seen and then told to bring the money in later if they did not have it. However, if they did not get the money, no issue would be made of the non-payment.

Health Care Policies

Nurses in the clinics explained that they were reluctant to prescribe medication without seeing the patients. Nurses operate according to the policies laid down for them, and some of these were not consistent with the needs of the caregivers. Nurses are not allowed to dispense medication without seeing the patient yet many patients were unable to come to the clinic.

Those family caregivers who were looking after bed-bound relatives often found themselves in a struggle with the health care system. In desperation, some would take the client's treatment cards to the clinic to try obtain medication. These caregivers reported that the nurses were reluctant to prescribe medication without seeing the patient. Even if the patient could be transported to the clinic once, the medication required visits on a regular basis (e.g., for hypertension) and such regular visits were prohibitive.

Attitudes of Health Professionals

Some health workers were reported to be unsympathetic and consequently alienating in their interactions with the caregivers. Some elderly people believed that health workers were guilty of ageism. One caregiver who visited the hospital on a regular basis because her husband was demented said this about the health workers:

> They said to me that I was afraid of keeping him at home because he was old, and because I wanted to dump him on them. The hospital people refused...they were difficult. They have abandoned us...I just keep taking him to the hospital... (CG07)

Another caregiver whose husband was mentally ill went back to the clinic to inform them that her husband had chewed up all the tablets which they had given him. The nurse's response to this woman's problem was: "It's not our problem if he has chewed up all the tablets." (CG07)

Access to Information

Lack of access to information served as a barrier to the role fulfillment of caregivers, as it impeded the execution of certain tasks or failed to facilitate taking care of the elderly person. This lack of access was often manifested in a problems of communication between health care services, lack of information about how the health care delivery system operated, and lack of information related to caregiving tasks.

Lack of Communication Between Health Care Services

In an interview with a nurse in charge of one of the clinics, I mentioned that some of the family caregivers were sorely in need of follow-up visits in the community. The sister-in-charge explained to me that in such cases, an effort was usually made to visit that family at home. She mentioned that even if no registered nurses was available, at

least an FWEs would visit the home. However, as a rule, there was no communication between the hospital and the clinics regarding the patients who were discharged and, as a result, the clinic staff had no way of knowing who urgently needed to be seen at home.

Lack of Knowledge Related to Health Care System Operations

Five caregivers and their family members lacked knowledge about how the health care delivery system functioned. When discharged from the referral hospital, one elderly man was referred to a health clinic nearest to his home for change of dressings and further management. The family members were upset by this arrangement and attributed it to the fact that the hospital no longer cared for their relative.

This misunderstanding often created resentment on the part of the family and the elderly person. The hospitals, for their part, were following standard procedures. Minor procedures like change of dressings and administration of injections were done at the clinic and not at the referral hospital. Lack of information sharing between health providers and clients also created a barrier which strained relations between the relatives of the elderly person and the health care delivery system.

Lack of Knowledge Related to Caregiving Tasks

Lack of knowledge of universal precautions made caregiving tasks risky to the caregiver's health, in some cases. This problem might be exacerbated by lack of equipment or amenities with which to carry out certain caregiving tasks. One caregiver washed soiled dressings of the care recipient so that she could use them again as there was no clean gauze to dress the wound. Other caregivers washed the soiled linen of incontinent elderly person without gloves which were not available. The majority lacked knowledge of universal precautions, in general.

One caregiver who was looking after her elderly husband with an indwelling continuous bladder drainage catheter spoke of some bags that had been given to her without explanation. As it turned out, the bags were uribags. When asked if the hospital had provided her with gloves for changing the uribags, she said no.

Another caregiver lacked skills to execute the caregiving tasks. One woman was observed teaching her daughter how to give an insulin injection to her father incorrectly. Her husband had recently been discharged from hospital.

Shortage of Supplies

There also was a problem of shortage of amenities or equipment and supplies, including drugs. One ill hypertensive patient complained of a pain between her shoulders. When asked if she were taking the tablets regularly, she explained that she had a prescription, but that the clinic had run out of the medication.

Caregiving Role Uncertainty

Another caregiver spoke of how she rolled her hemiplegic husband on the floor in an effort to massage his body. She felt this was helpful but complained of never having received proper instruction or information. Others spoke of being unsure and anxious about what they were doing, and thought that it would have been helpful if nurses could address these issues in community meetings. Clearly, the caregivers felt the need for support from the healthcare workers in what they were doing.

Some caregivers exhibited anxiety over how they were giving care. One caregiver who engaged in protective caregiving following her husband's stroke, did not allow him to make any decisions pertaining to running their business. Yet, at the same time, she expressed concern that she did not know if she was doing the right thing, or perhaps harming him psychologically by not allowing him to do some of the things he wanted to do. She mentioned that she wished some health worker could reassure her regarding the appropriateness of her decision.

Some caregivers also expressed need for rehabilitative care following hospital discharge for conditions like strokes. One caregiver wanted to know why her husband had not been given a walker. She mentioned that shortly after the stroke, her husband had been able to walk, but had now deteriorated. She blamed it on lack of rehabilitative care. Another caregiver was aware of the need for rehabilitative care following a stroke and questioned why the government did not offer such a service. She was aware that the service was offered for a fee by privately run physiotherapy practices, but mentioned that she could not afford it.

Caregiving can be stressful and caregivers needed the support of the professionals, particularly immediately following hospital discharge, as they make the transition from the hospital to the community. This is especially important given that there is no home-based care to support caregivers and their families through this transition.

Social Processes

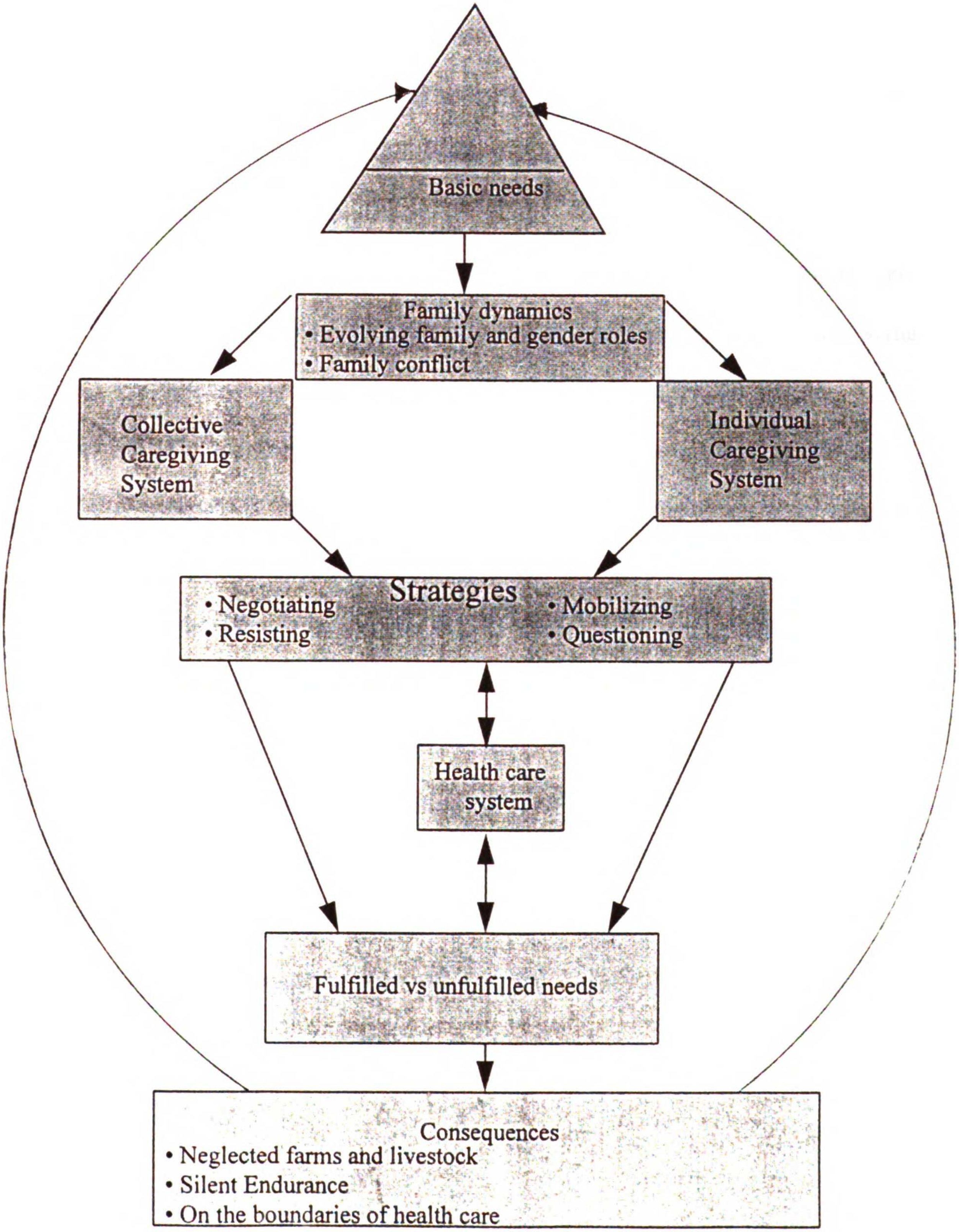
The interaction of intervening and contextual conditions discussed so far gave rise to the development of the basic process of caregiving on the edge, which consists of simultaneous processes of surviving on the edge and caregiving of an elderly relative (see Figure 4-2). The goal of surviving on the edge is to obtain the basics necessary for survival. Life was difficult enough for most of the caregivers in this study. With the added burden of caring for an elderly relative, the participants truly found themselves "caregiving on the edge."

The need to take care of an elderly relative set into motion the process of surviving on the edge, and the inherently difficult choices which had to be made in order to meet basic survival needs. The consequences resulting from an interaction of the socio-cultural evolution and socio-economic conditions, added to a health care delivery system which provided selective primary care, led to a marginalization of the elderly, most of whom found themselves on the periphery of health care access. For many of the caregivers, there were negative consequences like loss of a job or ability to engage in subsistence farming. They typically reacted to these catastrophes with silence, endurance, resignation, and helplessness. The coping strategies they employed included balancing, negotiating, resisting, questioning and mobilizing.

Resources had to be balanced in an effort to see to as many survival needs as possible. Caregivers juggled survival needs in order to sustain their families while, at the same time, caring for the elderly person. In balancing these needs, pragmatic but difficult decisions which threatened other important aspects of their existence, had to be made.

Figure 4-2

Model of Family Caregiving on the Edge



The care of the elderly was negotiated through interaction with kin in an effort to mobilize manpower and material resources. Family help was mobilized in the form of actual hands-on care, family remittances from those who were away working, and social support. Negotiations were necesary to resolve family conflict related to general care of the elderly relative and, specifically, to culturally appropriate care. Negotiation was also used to resolve tensions and conflicts which were created by dynamic social change within the normal relationships.

Resistance was another strategy that many caregivers frequently employed. The world of the caregivers was under constant assault by social and cultural changes. Some caregivers attempted to forestall the change and stay culturally connected to the traditional Setswana ways. Resistance took two forms: passive (or resigned) resistance and active resistance. The attempts of some of the caregivers to stay culturally connected were woven into their actions which were then called boundaries of acceptable options. These parameters stemmed from personal philosophies and cultural values regarding elderly care and assistance. Active resistance entailed maintaining cultural connectedness through an adoption of caregiving strategies which were considered in line with their culture. Consequently, in spite of their poverty, for example, some caregivers resisted help from the government in the form of a burial in a metal coffin, provided free of charge, and chose instead a Setswana burial which was not free of charge. The contextual condition of social change then structured family formations and patterns of family caregiving as individual or collective.

Another strategy that was used frequently was questioning. Evolving roles and values were questioned, and not adopted easily. Many individual caregivers, especially those who were in multigenerational families, could not comprehend some of the changes and questioned the lack of fulfillment of cultural expectations.

There was, furthermore, a time factor to the process of caregiving whereby caregivers would begin the role of caregiving believing that other family members would eventually assist them. In many cases, this initial faith was transformed by the sudden realization that family help was not forthcoming and, that the condition of the elderly relative was not going to change. Often, this resulted in disappointment and may or may not have led to a change in the strategies used to provide care.

Summary

Results of this study point to the important role played by the family in elder care. Family care of the elderly was situated in a macro environment characterized by a relatively stable political environment, a poor socio-economic climate, considerable social change, cultural determinants, and a health care delivery system directed by health policies that did not facilitate access to health care for the aged.

Social change was evident in the evolving family structures which reflected a continuum between collective and individual caregiving systems. According to where the families fell along the continuum, the strategies engaged in by different family members reflected the caregiving system upon which it was based. Caregiving was provided, in many instances, under very difficult circumstances. Poverty permeated many aspects of the lives of the family caregivers, affecting their ability to satisfy even the most basic of human needs such as food and soap.

Many caregivers suffered adverse consequences as a result of giving care to the elderly relative. In the absence of institutional care and with minimal community resources, family caregivers endured many hardships in silence and looked forward to a bleak future and no immediate change in their situations.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS OF CAREGIVING ON THE EDGE

This study investigated the experiences of family caregivers of the elderly in Botswana using grounded theory methodology developed by Glaser and Strauss (1967) and Strauss and Corbin (1990). Participants were recruited with the assistance of Family Welfare Educators (FWEs) and social workers from the capital city of Gaborone, and two other rural villages Shoshong and Kalamare, in the central district of Botswana. Twenty four family caregivers were interviewed individually and in small groups.

The aims of the study were to: (1) identify the family caregivers of the elderly; (2) describe the experiences of the Batswana family caregivers of the elderly; (3) describe Batswana family caregivers' perceptions and appraisals of caregiving; (4) identify caregivers' needs and sources of help during the caregiving process. This chapter will briefly review the results of the study, and discuss their implications for health services, nursing practice, primary health care, research, and policy.

Caregiving on the edge involved the simultaneous tripartite processes of surviving on the edge while giving care to an elderly relative, being in the cultural borderlands, and existing on the boundaries of the health delivery system. Caregivers in this study were preoccupied with basic survival needs because of their abject poverty. Those who were so constrained by their caregiving activities as to be unable to engage in agricultural activities were adversely affected, since they relied on agricultural farming for food production and subsistence living. In the rural areas, many of the families in this sample lacked able bodied persons who could help with agricultural chores. This can be explained by the high rural to urban migration. However, while adversely affecting the lives of many caregivers, migration to urban areas was a rational economic decision for those in search of economic betterment, and is therefore a survival strategy for the poor (Hope, 1997).

There has been a massive exodus from traditional family agriculture since the last drought in 1981. Traditional family agriculture occupied 33% of the labor force in 1984 and only 15% in 1991 (Jefferis, 1993). Traditional agriculture in Botswana is therefore deteriorating and has a limited potential for generating income in comparison to other types of economic activity (Hope, 1997). The changes in the family, although gradual and not usually a complete break with the traditional extended family, reflect the growth of individualism, geographic and social mobility, and the declining hold of the extended family and the familial mode of production over the forces of production (Gordon, 1996). Yet, the limited educational experiences of the participants also restricted their opportunities to enter the labor force as did the fact that many were both illiterate and old.

Botswana's impressive macro-economic performance has been well documented (Harvey, 1992; Hope, 1997). Yet, in spite of the country's record of successful economic development and management, there is increasing concern over what seems to be persistent poverty and deepening inequality. Indeed the findings of this study reflect the presence of abject poverty in spite of the country's record of successful economic development and management. This finding is supported by a study conducted by Guillette (1990) that also found high rates of poverty among rural elderly in Botswana.

Therefore a logical starting point for a discussion of the situation of family caregivers in Botswana is the role of the extended family in family care.

It is well documented in the literature that the African conceptualization of the family revolves around the extended family as an important unit of analysis and also as the basis for the sustenance of society (Kaseke, 1996.) The migration of rural residents in search of better jobs in the city has disintegrated the traditional multi generational households, particularly in the rural areas. The extended family in Africa has been weakened by countervailing forces created by capitalism. Consequently social classes, the nuclear family and individualism are growing among those exposed to western education and culture as well as to urban life (Gordon 1996). Fifty percent of the study subjects reported family remittances as an important source of income especially for those family caregivers who were not working. However, financial help from urban relatives was inconsistent, making it difficult for unemployed or low income family caregivers to meet their needs.

One of the reasons that has been given for the persistence of poverty in Botswana is the fact that 32% of the households have no family member in the formal sector employment (Hope, 1997). Study subjects admitted that it was unrealistic to even expect any remittances from their family members, as they were also impoverished. The willingness of the extended family to continue to support other family members, especially older ones was not questioned. However, caregivers understood the nature of economic constraints on their children who had moved away from their homes to set up their own homes. This finding is supported by a study conducted by Togonu-Birsketeth

(1989) that found that in Nigeria, although the adult children supported their parents, the current practice of parent support burdened the adult child and also failed to yield a desirable level of support for the parent.

The availability of financial resources was pivotal since families thought providing food and shelter was the key element of caregiving. Since lack of resources compromised the ability of caregivers to effectively render care, caregivers expressed anguish over their inability to fulfill this important role.

Botswana is currently experiencing rapid change from a largely peasant-dominated society to a modern capitalist state (Hermans & Nteta, 1992). The declining birth rate of child bearing women means that more women are now able to enter the labor force. This will mean fewer children for future cohorts of elderly to draw upon for support (Eggebeen, 1992; Treas, 1977).

According to Gordon (1996), the slow shift taking place from a communitarian to an individual society has a corresponding effect on gender relations. Gender roles seem to be changing along with the social change. Most caregivers in this sample seem to think that girl children are more reliable caregivers than boy children. This finding is supported by Ngome (1994) who found that in Botswana, elderly people seem to think that daughters are more responsible and caring than sons. Yet, findings from this study suggest that while daughters were reported as more active in providing parent care, sons are not altogether absent from support roles. They contributed financially, with home repairs, collected firewood, assisted in the fields, and in some cases, assisted with personal care, especially if the elder was a man. Silverstein and Waite (1993) also reported that sons contribute with home and car repairs as well as financial assistance to their aging parents. According to Bengston & Silverstein (1993) as a result of the structural shift in family intergenerational compositions, the sharp gender related division of labor in social support will blur as gender related norms become less rigidly defined. There will be added pressure on sons who will be less likely to have a sister or wife to share the responsibility of parent care. In contrast, Spitzer and Logan (1990) maintain that having at least one daughter was the key to receiving help. And some elderly caregivers in this sample complained that their daughters and grandchildren dumped their children on them.

There seems to be contradictory evidence regarding gender differences pertaining to caregiving even in the western literature. Regarding caregiving studies which have focused on gender differences, Horowitz (1985) found that daughters as caregivers provided more assistance to aging parents in the form of transportation, household chores, meal preparation, errands, shopping and personal care than did sons. Sons were more likely to assist with decision making and financial assistance. In contrast, Miller (1987) found relatively few differences between men and women regarding task support and caregiving involvement.

The findings of this study depart from the caregiving literature findings of the western countries, which emphasize needs are completely different from those reported by caregivers in Botswana. When asked what they needed, Batswana caregivers mentioned basic survival needs like food, sanitation, soap, and shelter. These results are similar to those of Guillette (1990) who reported that in Botswana, perceived needs concentrated on necessities, mainly food, clothing and soap. In contrast, the western caregiving literature focuses on the need for flexible work schedules, psychological counseling and respite care by focusing on provision of supportive assistance (Biegel & Blum, 1990, Crossman, London, & Barry, 1981; Horowitz & Dobrof, 1982; Montgomery & Borgatta, 1989; Montgomery & Prothero, 1986). Such needs were irrelevant for the Batswana caregivers.

Botswana has very limited services for the elderly. It wasn't until late 1996 that services were available for the elderly. These services were mainly for the elderly who were destitute. In October 1996, the Botswana government instituted a social security payment of P100 for all people aged 65 and above. This is considered timely since there is ample evidence that the role of the extended family as a traditional welfare system is weakening. Many caregivers interviewed were skeptical about this pension scheme, questioning whether the government had the economic capacity to provide this payment to all those who were eligible, especially those in poverty. Some caregivers felt the amount was too little to be of much use, while some felt that it would at least provide a few necessities, such as soap.

Urbanization and exposure to western values have led to questioning and modification of existing expectations, leading to a conflict in values. Caregivers expressed much disappointment about the transition from collective caregiving to individual caregiving, as well as the inequitable contribution to the caregiving situation by other members of the kin. Because this was not a cultural norm, many caregivers found this to be one of the most difficult things that they have ever faced. In the western literature, one study reported that although individualists felt obligated to care for aging parents they did not believe that caregiving should fall to only them (Pyke & Bengston, 1996).

According to Gordon (1996) Africa is in a transitional period between its collective past and a more individualistic future characterized by variations in the degree to which and by whom kinship values are upheld or rejected. However, among the younger, more educated urban Africans, there was ambivalence about the decline of traditional life in the face of growth and the attractions of the modern capitalist economy.

The two caregiving systems, the collective and individual reflected two worlds sometimes blending together and sometimes distant from each other. Different families were at different places along the transition from collectivism to individualism. Changes from collectivism to individualism can have different forms on many levels and are not a simple bi-polar dimension (Reykowski & Smolenska, 1993). Alexander's (1995) rendition of the two cultures does not bridge the distance between the two worlds. Rather she sees the space between the two worlds as the difficult historical ground, in which the post colonial seeks his or her cultural identity, and distances the self in order to understand oneself as an historical being. Rosaldo refers to this space as the cultural borderlands (1989). In a study that was conducted in a Botswana village, the problem encountered by the elderly in the face of social change was how to make sense of the new situation in the context of historical traditions (Bruun, 1994).

In this study, families reported that one of the difficulties associated with the social change was an abandonment of traditional ways of doing things. In an effort to resist this change, family caregivers tenaciously clung to their traditional ways of living in order to affirm their continuity with the past. They frowned upon caregiving strategies which departed from the traditional culture. For example, providing elderly with western food was not viewed as helpful. Obtaining paid help to assist with intimate care was also considered inappropriate.

Many caregivers endured caregiving without complaining. This finding was initially very puzzling, until it was analyzed from a cultural perspective. Suffering in silence is embedded in a culture which emphasizes perseverance in the face of hardship. To endure hardship in silence is a virtue which in the old days was emphasized for both boys and girls in initiation schools. During this process women were prepared for the extreme pain of childbearing. Men were circumcised without any anesthesia. Cultural training emphasized endurance of physical and emotional pain without screaming to the point that when the missionaries first came they used to think that the African did not feel pain, as they pulled teeth out and noticed the reaction of the Batswana (Kupe, Personal Communication, 1997).

Even in preparation for childbirth, there is a lot of emphasis on bearing the pain of childbirth in silence. To scream in pain is considered a disgrace to the woman herself and her family. In preparation for marriage, again one is psychologically conditioned for putting up with the hardships of marriage. Consequently, suffering in silence is considered virtuous in the Setswana culture, and may explain the silent endurance in caregiving.

It is interesting to note that men who were caregivers in this study, even those doing so under extremely difficult conditions, did not complain. These men were divorced and mentioned that they felt that it was clearly the role of the women to do what they were doing. One man said, "that men could not take care like women do." He was the caregiver in this situation because his sister who was supposed to be taking care of their mother was in and out of the hospital. Another male caregiver was taking care of his father because his wife had left him. He was the eldest son in a family with no daughters. Both men talked about the difficulties they faced in the role of caregiving. Just like the female caregivers, these men felt that they must endure the hardships of caregiving without complaining.

There were differences in the way different age cohorts reacted to the caregiving situation. Family members who were reported to have abandoned elderly relatives tended to be younger. The migration of younger people from rural areas to urban areas may explain this. Ingstad, Bruun, Sandberg, & Tlou (1992) report that rather than poverty's reinforcing reliance on kin, young Batswana are responding by withholding resources from their relatives including their elderly parents to avoid falling into poverty or having to rely on kin for economic assistance. To an increasing extent, younger members of the African extended family are detaching themselves from reciprocal extended family relationships, preferring to strive for success in a more nuclear family context.

Most of the caregivers in this study were themselves elderly or in their fifties or late sixties. Older caregivers had reached adulthood between the early 1940s and 1950s, experienced a common set of norms that probably reinforced how they readily took on the role of caregiving for their elderly relatives. Some of these elderly and late middle aged caregivers may have attended initiation schools which emphasized the cultural training of silent endurance.

One such caregiver actually said to me when I questioned that she did not seem to be dwelling much on the difficulties encountered in caregiving, "I do not know, perhaps it is secrecy." The Setswana culture emphasizes maintaining family secrets, hence the saying that “when family issues are discussed, the doors and windows should be closed.” This metaphor refers to the fact that what is discussed in the home is kept behind closed doors and should not leak out. The English equivalent of this metaphor or philosophy would be that washing one's dirty linen in public is something that is frowned upon.

Silent endurance did not mean that caregivers reported their situations as easy; they did acknowledge the difficulties experienced in caregiving. Yet, there was a sense of helplessness and despair regarding the family caregiver's plight. This may have been due to the fact that some families were struggling with basic needs. Many caregivers did not expect any change in their current circumstances.

This does not mean that these caregivers had no emotions. To the unsuspecting onlooker at face value, these caregivers seemed devoid of emotion because of the stoic manner they their needs were expressed. However, painful emotions were frequently evoked during interviews. One caregiver who was caring for her grandmother cried as she talked about the death of her mother. There was pain and anguish on the faces of two other widows who talked about the recent deaths of their husbands.

Lack of Access to Health Care

Lack of access to health care emerged as a barrier since elderly caregivers were unable to walk to the health facilities. Access to primary health care is integral to an elderly person's general health and quality of life. Yet lack of consultation fee, transportation and community based home care made this health care inaccessible. Tlou and Sandberg (1994) also reported that the elderly were less able to pay for a hired vehicle or donkey cart to take them to the clinic.

In this study, transportation and lack of consultation fee were related to lack of financial resources. Many subjects in this study mentioned that they could not afford to hire a vehicle to transport an elderly relative to the clinic, or indeed to pay the two pula consultation fee. In rural areas, most people who could afford to hire transport for an elderly relative, tended to hire the clinic vehicle because it was cheaper than using public transport. However, although the clinic does allow the vehicle to be used for such purposes, the clinic vehicle is really provided for purposes of facilitating the operation of the clinic. It tends to be used to transport staff to deliver care to the remote areas and for administrative purposes, like transporting staff to meetings. On those days when the vehicle had been sent off on other errands, it would not be available for purposes of transporting sick patients to the clinic, or the nearest hospital.

In another study, transportation problems were not only experienced by clients in the community, many community health nurses seemed frustrated by constraints on their practice, and one of them was lack of transportation when they needed it (Anderson, 1987). Problems of transportation are therefore embedded in the allocation of scarce

resources of the Ministry of Health and the country at large. FWEs also had to walk to their home visit sites and in some large villages, this was time consuming. Some rural areas were quite large and spread out. Consequently, it was difficult to do home visits to all families who needed it. Furthermore, there seemed to be an inequitable distribution of personnel. Urban areas had more FWEs and even in rural areas, larger villages were only staffed by two FWEs.

Implications for Nursing Practice

The lack of access to health services points to the need for an outreach program. The findings of this study suggest the need for changes in the practice of nurses when dealing with elderly patients who are frail and bed bound. Needed changes include the following: (a) community assessment in order to identify the frail elderly especially those who need health services but are unable to get to the clinic; (b) outreach programs that target the elderly people and are designed for the needs of this population; c) education about the normal aging process, provided for health care providers, caregivers and the community at large; and (d) an evaluation of present services for different age groups, with a particular emphasis on the impact of services on the elderly.

Community assessment is an essential requirement for any institution that provides care to the community. This should be done periodically in order to capture the emerging trends in the community and to determine the magnitude of the problem. Nursing interventions for the elderly must support and build on family caregivers' strengths and limitations. This requires a change in philosophy from the current practices of assessing and treating patients. Efforts must be made to make available both curative and preventive care to the elderly who cannot gain access to the clinic or hospital. Quite often, all that is needed is a refill for drugs prescribed for chronic illnesses like hypertension and joint pains.

Education of the community in general about the normal aging process could at least alert the family caregiver to abnormal changes occurring in their elderly relatives, and therefore alert them to seek early treatment. Several care recipients (25%) in this study were blind, and yet some (12%) of them had never been to the clinic for an assessment to rule out the possible cause of blindness. It was assumed that old age caused blindness. In a study that was conducted in Mankgodi (Botswana), it was reported that blindness was the most common cause of physical disability diagnosed during physical assessment, 57% of the sample was blind. Cataract was the commonest eye disease encountered, with a higher incidence among women than men (Clausen & Sandberg, 1994). In yet another study, blindness was a major health problem among women than men (Ngome, 1994).

There seemed to be a need for supporting newly discharged patients for the first few days as they struggled with mastering newly learned skills like changing uribags and giving insulin injections. The patients were generally taught these skills before leaving the hospital, but given the literacy rate of some of them, it was overwhelming to some of the caregivers. There seems to be a need for home health programs to support newly discharged patients back to the community.

There is a need for closer communication between the hospital and clinics about patients who were discharged. Although Botswana does not have a full fledged home based care for all patients, some of the clinic nurses mentioned that they would be willing to closely monitor those patients who needed extra help following discharge through the use of FWEs (Clinic RN, Personal Communication, 1996). The movement of elderly patients between the rural and urban homes of their kin would also make follow up care of elderly people in the community difficult. Community Health Nurses were aware of the lack of the curative and preventive balance in their practice as most of their time was taken up by clinic duties (Anderson, 1987; Clinic RN, Personal Communication, 1996).

Presently only Registered nurses and Enrolled nurses (Licensed Practical nurses) are allowed to prescribe drugs in the clinics. Given the present manpower constraints, the Community Health Nurses are not always able to do home visits and dispense drugs. Some outreach program has to be devised to ensure that the elderly people who were not mobile could at least be assured of obtaining their drugs even if they could not gain access to the clinic or other health facility. However, people who prescribe drugs for the elderly must be properly trained and educated to understand the special pharmacokinetics and pharmacodynamic characteristics of the elderly, particularly the very old (WHO, 1989).

In Botswana, nurses comprise the largest number of health care personnel and are deployed to the rural areas where most elderly people live. Nurses need to act as advocates for the elderly. Nursing intervention should not only focus on informal family caregivers' responses to their roles, but also beyond these responses as these manifestations are processes that are located in the context of the social, political and economic world within which they are situated. The environment or setting within which the humans experience everyday life has not been the focus for intervention and action by nurses (Chooporian, 1986).

Proposed ways of assisting the elderly should not only include provision of material resources, but also support for the traditional extended family (Guillette, 1990). Community participation, and advocacy based on the principle of social justice, can be used to lobby for a social policy that addresses the problem of caregiving in a shifting environment.

Some caregivers reported to have experienced ageism from health personnel as they interacted with them. Ageism is defined as both negative stereotyping of and discriminatory behavior toward old people (Jefferys, 1996). Participants reported that health practitioners seemed to think that some caregivers took their elderly relatives to the hospital to simply dump them on the health personnel. This might happen for respite care when no family or formally paid caregivers are available in the area where the elderly person and family resides. Some caregivers reported that their relatives had been chased out of the hospital because they were old. Practitioners often confused consequences of ageing and illness, such that when elders sought help for genuine health reasons, meaningful complaints were dismissed as age-related or typical of gerontized communication (Henrard, 1996).

In the study, information sharing by health personnel was lacking at both clinic and hospital level. Health professionals should be encouraged to communicate about the client's condition in order to ensure more continuity of care and to allay the anxiety of both the patient and the family.

In light of the significant changes in the demographic profile, migration patterns, declining fertility rates, family structure, socio-economic and political climate that have been alluded to, it is important to recognize that these factors contribute to the problems faced by clients and their families. Rather than expect the client to adapt to the environment, action has to be not only directed to the consumers of health, but also focused on the environment, to make it possible to address more effectively the needs of the elderly.

Poverty and Health

One of the important findings of this study is the extent to which poverty permeated all aspects of family caregivers' lives and contributed to the poor health of many elderly people and their caregivers. The socio-economic status of households determined whether families could afford transportation to gain access to health care, had food to eat, and lived under sanitary conditions. Lack of financial resources was mentioned as the major barrier to seeking health care (Tlou & Sandberg, 1994). According to WHO (1995), the world's biggest killer and the greatest cause of suffering and ill health across the globe is extreme poverty. Those who were wealthy by village and urban standards, were healthier, had food, sanitation, and access to both government and even expensive private health care. In some instances, the poor could not even afford eyeglasses. This became even more important when caregivers relied on their sight to give medication like insulin.

Health Manpower

The Ministry of Health (MOH) realizes that shortage of personnel is the critical constraint in satisfactory delivery of health services, and that its training programs and recruitment of expatriates (foreigners) have fallen far below targets (Ministry of Finance and Development Planning, 1994).

The difficulties that community health care nurses face are related to the health care system and other macro-economic issues. Nursing does not operate in a vacuum, but in a health care system based upon established policies which in turn shape the scope of nursing practice.

Primary Health Care

Although the effectiveness of the PHC strategy is still being debated, many analysts agree that when diligently pursued, lowered disease and mortality rates are testimony to the effectiveness of universally accessible PHC services, especially in the rural areas (Morgan, 1993). In Botswana, the infant mortality rate decreased from 100 to 38 live births. The life expectancy of elderly people has risen from 56.2 in 1981 to 61.7 years (Republic of Botswana, 1991). Yet, the Botswana health care delivery system has not evolved to address certain age groups. For example, the elderly, family, and community as a client. Consequently there is a mismatch between the health care delivery system and the needs of certain special populations. Health resources are not distributed over the life course.

Nurses comprise the largest number of health manpower personnel in Botswana. Therefore, the primary health care as a philosophy of practice gives more responsibilities

to nurses than other cadres. Primary care includes among its slogans that health care has to be affordable and accessible to the people. Yet, the elderly people in Botswana found health care both unaffordable and inaccessible because of transportation problems. Transportation problems were more exacerbated in the rural areas than in urban areas. This is not surprising given that the infrastructure is generally more developed in urban areas than in rural areas.

Implications for Health and Social Policy

Several key points related to the formulation of a health policy that is age sensitive emerge from the data collected in this study. First, appropriate health care policy for the elderly requires an understanding of family functional activities and limitations, as well as a recognition of the resources available to family caregivers. Policy should take into consideration the full range of caregivers' activities, and the conflict between this role and family members responsibilities as producers and workers (Kettel, 1996), and often as heads of households. Top down approaches to policy formulation will not address some of the problems central to the caregivers and needed modifications to the health care delivery system. Therefore, a participatory approach will be more empowering and more in line with the dictates of primary health care. Health care imperatives, which health policy needs to address, include rehabilitation, prevention, health promotion and maintenance, and a health care policy which takes into consideration the demographic transition.

It is disconcerting to realize just how little is actually known about the health problems of the elderly people in Botswana. A detailed understanding of how aging

impacts on their interaction with the existing health care system and exposes them to health risks is essential to articulating and promoting policy that is sensitive to elderly issues. The availability of a clinic within a radius of 15 kilometers, while commendable, is meaningless to the health and quality of life of the elderly if they cannot gain access to these facilities.

Presently, sources of health and social services for the elderly in Botswana fall under three government institutions (ministries), the Ministry of Health (MOH), Ministry of Labour and Home Affairs (MLHA), and Ministry of Local Government Lands and Housing (MLGLH) which have overlapping and complimentary responsibilities for the elderly. MOH is responsible for health policy and planning, MLHA is responsible for social security and social welfare, and MLGLH implements health and social welfare services through local authorities. However, the functions of these ministries regarding aging issues are uncoordinated (Mugabe, 1994). Clearly a more integrated approach to provision of the elderly is advocated, and it would also utilize intersectorial collaboration advocated in PHC.

Many elderly people were reported to equate institutionalization with imprisonment, and preferred to be mistreated by their own children than by strangers (Ngome, 1994). Therefore, policies emanating from identified needs must be acceptable within the cultural framework, and the families must be seen to play a part in the formulation of such policies in order to empower them. Some family members seemed unaware of the family caregiver's needs. Given the propensity for stress and the possibilities for intra familial conflict engendered by caregiving, it can be important to assist families to maximize opportunities to share the caregiving, and be aware of the family caregivers' needs (Keith, 1995).

Implications for Research

There is a need to replicate this study in other parts of the country, with caregivers of specific age groups of elderly people. The specific age groups could be those aged 60-75, and 75-100 in order to explicate the needs of caregivers according to age cohorts. Future studies should include more male caregivers to explicate the gendered nature of caregiving. Research that focuses on the contexts which create gendered behavior may provide an understanding of the gendered nature of care (Walker, 1992). Caregivers from male headed households and middle and high socio-economic families should be included, since this study provided data from a largely impoverished population.

The Botswana society is in transition, and consequently in the face of rapid urban to rural migration. Some individuals found themselves at the juncture of two cultures, the traditional Setswana and western influenced urban culture. As they straddled the borders of these two cultures, some individuals suffered the consequences of border clashes. Manifested in conflict and disappointment by other family members who strongly resisted the change. "Such borderlands should be regarded not as analytically empty transitional zones, but as sites of creative cultural production that require investigation" (Rosaldo, 1989, p208). An understanding of the concomitant problems of the caregivers in view of the socio-cultural evolution will assist in the structuring of programs which can better assist the families in the care of their elderly relatives.

Interviewing family members of those family whose members disengaged themselves from caregiving could elicit an understanding of the processes that inhibit other family members from contributing to the caregiving situation. An assessment of enabling and constraining factors could be useful in understanding some of the prevailing family dynamics related to the care of the elderly.

Additional research is needed to accurately characterize the health status and needs of the growing number of elderly people, especially the homebound ones. This will be of importance in the planning of their health needs, formulating health policy pertaining to this age group, and in structuring outreach programs.

In western countries, the caregivers who were available for the old-old tended to be old themselves with higher risks of morbidity and mortality (Fischer & Hoffman, 1984). In this study, some caregivers were themselves elderly men and women taking care of frail aged parents, and some of them were themselves unwell. One caregiver summarized this scenario when she said "a patient is being taken care of by another patient (molwetsi o tlhokomela molwetsi yo mongwe)". Further studies need to be done to assess the prevalence of older caregivers and their own health care needs.

Two churches were reported to assist 11% of the participants in this study. A study should be done to assess the role of non-governmental organizations and churches in assisting family caregivers in the care of the elderly.

Limitations

Family caregivers who were recruited into this study were mostly from low income families. At the time of data collection there was no listing of family caregivers.

However, a list of all elderly people aged 65 and above was in the process of being compiled for purposes of social security income which was introduced in October 1996. Therefore, in the future, it may be possible to include family caregivers who were from higher incomes.

The annual rotation of FWEs in the city was a setback in that they were new and therefore not familiar with the elderly population in their catchment areas. Further, interviewing family caregivers over a period of time would have allowed time to establish rapport, and also observe the process of family caregiving over time. For those caregivers whom I visited thrice, I was able to see changes in their affect over time as the elderly person's condition deteriorated.

Conclusion

The purpose of this study was to investigate the experiences of family caregivers who were taking care of elderly people in Botswana. Results presented here must be interpreted within the limitations imposed by the sampling procedure used in the study. The sample was limited to 24 elderly caregivers who were mostly of low-income. Second, the data is cross-sectional in nature rather than longitudinal, so that any implications of cause and effect must be later tested with longitudinal data. While the results of this study cannot be generalized to the entire population of Botswana, they do provide the foundation upon which to raise questions regarding the dominant conceptions of PHC and the current health policies and practices in Botswana.

Several issues that are relevant to the health of the aged have been identified. The health problems of the aged, are rooted in social, economic and political determinants.

Lack of access to health care is to a large extent a manifestation of poverty and also related to the way the health care delivery system is structured. What ultimately determines whether a population is healthy or not is primarily the socio-economic setting within which poor health develops (Giacaman, 1988). In light of this, the findings of this study underscore the need for a healthy policy that addresses the demographic transition by providing health care services which will address the needs of the elderly, given the poverty within which they are embedded. The numbers of the elderly are likely to continue to increase, given the gains of biomedical science and the availability of the curative services.

In conclusion, in light of the aforementioned trends such as change in the demographic profile of the population, environmental changes, family structure, advancing age of the elderly, and the few studies available on the elderly in Botswana, one can hardly be optimistic that the current family informal support or caregiving is adequate for the elderly population's needs in terms of their structural and resource prerequisites. Given the accompanying effects of chronic illness that accompany aging, and the arduous nature of rural life, caregiving to the elderly in Botswana poses a great challenge. The government needs to reconsider its existing social policies (Ingstad, Bruun, Sandberg & Tlou, 1992) as elder care will only be more complex and entail more responsibilities for family caregivers.

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APPENDIX A

Demographic Characteristics of Batswana Caregivers

Gender
0=male
1=female
Age______
Level of education
0=none
1=primary school
2=High School
3=other
Residence
    0=Rural
    1=Urban
Number of people in household_____
Care recipient's relationship
    0=Mother
    1=Father
    2=Mother-in-law
    3=Father-in-law
    4=Husband
    5=Wife
    6=Other
Own health
    0=Excellent
    1=Good
    2=Fair
    3=Poor
Owner of residence
    0=Caregiver
    1=Care-recipient
Where do you stay during the ploughing season?
    0=Home
    1=Fields/Lands
If lands who stays with the care recipient in your absence?
What is your source of income?
    0=Subsistence farming
    1=Paid employment
    2=Children/Family contributions
    3=Other
Are you employed at a paid job?
    0=Yes
    1=No
If yes are you employed
    0=Full-time
    1=Part-time

If no did you have to give up paid employment to take care of the care recipient?
How long has the care recipient been ill?
What is wrong with the care recipient?

APPENDIX B

Interview Guide

Please tell me how you came to be caring for___________
What is the reason the care recipient needs your help or cannot do things on his/her own?
How long has the care recipient needed help from you because they cannot do things on his/her own?
What has this been like for you?
Please tell me what a typical day is like in terms of your caring for____________
For how long has ___________ needed assistance?
Could you tell me about the kind of help you give?
Are there any services in your community that could help you take care of your older relative?
Who else helps you with doing some of your tasks for ________? Another family member? Friends?
Can you describe to me what the hardest thing about caring for ______________ is if you can?
What makes it easier/more difficult?
What other family work do you do?
What other on-going household/farm maintenance work do you do?
Does caring interfere with this?
How do you handle these problems?
How do you deal with all of the things you have described?
Think about the time when you started caregiving till now, would you tell me how this responsibility has unfolded for you?
How have your responsibilities as caregiver for _________ affected your life?
Did you have any experience with caregiving prior to this?
Can you tell me how you think things will go in the future?
Who would you like to take care of you if you ever need help as an elderly person?
Who do you think should give care to an infirm elderly person?
I would like to ask you about your health in general. In the light of all that you have told me, how would you rate your health?

APPENDIX C

Information Sheet

INFORMATION SHEET

RESEARCHER: Sheila Shaibu, Doctoral Candidate
Department of Physiological Nursing
N611Y, Box 0610
University of California, San Francisco
San Francisco, CA 94143-0612
415-731-4577

SUPERVISOR: **Margaret Wallhagen**, RN, PhD
Dept. of Physiological Nursing
N-631Y UCSF Box 0610
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415-476-4965

PROJECT TITLE: FAMILY CAREGIVERS OF BATSWANA ELDERLY

A. PURPOSE AND BACKGROUND

Sheila Shaibu, a doctoral nursing student, is conducting a study to understand the experiences of Batswana family caregivers of elderly people. Professor Margaret Wallhagen will be supervising her. I have been asked to participate in this study because I take care of an infirm elderly person at home.

B. PROCEDURES

If I agree to participate in the study, I will talk with Sheila for about 45 minutes to an 1.5 hours in a comfortable place such as my home or another agreeable place. The interview will focus on my experiences with taking care of an elderly person. If I approve, the interview will be tape recorded. If I do not approve, Miss Shaibu will take notes.

C. RISKS/DISCOMFORTS

Participation in research may involve a loss of privacy. Study records will be kept as confidentially as possible. Only identification numbers will appear on any written records and these will be kept in a locked file. If the results of this study are published in any scientific journals, my identity will not be disclosed. Only members of the research team will have access to the research data. After the study has been completed, the audiotapes will be erased and any written identifying data will be destroyed. If I find some questions difficult or unpleasant to answer, I may decline to respond to that question or I may completely stop my involvement in the study at any time.

D. BENEFITS

There are no direct personal benefits to me for participating in the study. However, the information I provide may help policy makers and nursing staff to better understand what it is like to take care of an elderly person, and hopefully set up appropriate policies and programs.

E. COSTS/REIMBURSEMENT

There will be no costs to me for participation in this study, nor will I be reimbursed for participation.

F. QUESTIONS

I have talked to Sheila Shaibu about this study and have had my questions answered. If I have any additional questions I may contact the Office concerned with the protection of Human Rights at the Office of the President in Gaborone.

If I have further questions or comments about participation in the study, I should first talk with the researcher, her Head of Department, or her faculty advisor. If for some reason I do not wish to do so, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the Committee Office at the Office of the President between 7:30 a.m. and 4:30 p.m., Monday to Friday, by calling 350808 or by writing to the Permanent Secretary to the President, Office of the President, P. Bag 001, Gaborone.

G. CONSENT

I have been given a copy of this information sheet to keep.

PARTICIPATION IN THIS RESEARCH IS VOLUNTARY. I am free to decline to be in this study, to withdraw from it any time, or to refuse to answer a particular question. My decision as to whether or not to participate in this study will have no influence on seeking care for myself or any member of my family at the local health clinic.

University of California San Francisco
Committee on Human Research Approval #H6362-12407-01
Committee Phone Number: (415) 476-1814.

Office of the President, Botswana
Phone Number: 350808

APPENDIX D

CHR Letter

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH AFFAIRS, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

April 4, 1996

Margaret I. Wallhagen, Ph.D.
Department of Physiological Nursing
Box 0612

Re: "Family Caregiving in Botswana" (CHR Approval #H6362-12407-01)

Dear Dr. Wallhagen:

The response and revised information sheet for the above protocol were recently received in our office. After review and because the change to the information sheet requested in our letter of January 11, 1996 has been made and approved, the condition has now been removed from your approval. Your approval number remains H6362-12507-01 and the expiration date January 15, 1997.

Sincerely,

Sharon Friend

Sharon K. Friend
Principal Analyst
Committee on Human Research

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Enc.

cc: Sheila Shaibu, M.S.

APPENDIX E

Letter from the Office of the President

TELEGRAMS: PULA
TELEPHONE: 350849
TELEX 2655 BD

REPUBLIC OF BOTSWANA

OFFICE OF THE PRESIDENT
PRIVATE BAG 001
GABORONE

Tel: 350808

OP 46/1 LII (29)

March 1, 1996

Sheila Shaibu
University of Botswana
Private Bag 0022
Gaborone

Dear Madam,

<u>RE: GRANT OF A RESEARCH PERMIT</u>

I refer to your application for a research permit dated 2nd February, 1996.

I am pleased to inform you that you have been granted permission to conduct research on "<u>Family Caregiving of the Elderly in Botswana</u>." The research will be conducted at Shoshong, Kalamare and Gaborone for a period not exceeding 12 months effective March 1996.

The permit is granted subject to the following conditions:

1. Copies of any papers written as a result of the study shall be directly deposited with the Office of the President, Ministry of Health, Ministry of Labour and Home Affairs, National Library Service, National Archives and National Institute for Research.

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2. You work in a close and unrestricted with local authorities, Ministries of Health and Labour and Home Affairs.

Yours faithfully

U. Sethibe
<u>for/PERMANENT SECRETARY TO THE PRESIDENT</u>

cc: District Commissioner, Mahalapye, Gaborone
Director National Library Services
Director National Institute for Reseach
Government Archivist
Permanent Secretary, Ministry of Health
Permanent Secretary, Ministry of Labour and Home Affairs