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“WOMEN HAVE NO TRIBE”

Connecting Carework, Gender, and Migration in an Era of HIV/AIDS in Botswana

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The country of Botswana currently has one of the highest HIV infection rates in the world. Government and international aid agencies have undertaken initiatives to address the rapidly growing epidemic, but few measures address the current crisis of care as a key element in that process. In this article, the author uses case study data to highlight how women in Northern Botswana are affected by the increasing burden of caregiving to children who are orphaned as a result of the HIV/AIDS epidemic. In particular, she describes how the role of women as caregivers in communities has been transformed as a result of the HIV/AIDS crisis. She suggests that the intersecting cultural patterns of migration and reproduction are central to understanding the spread of the disease in the current emerging crisis of care.

Keywords: Botswana; HIV/AIDS; fosterage; migration; reproduction

In this article, I highlight the role of gender in the HIV/AIDS epidemic in Botswana, the crisis of care it has unleashed, and the failure of current efforts to stem the rise of HIV infection in the country. Botswana currently has one of the highest HIV infection rates in the world. Deaths among working-age adults have orphaned large numbers of children, producing a crisis of care and undermining a traditional fosterage system that previously helped to support women. Women bear the burdens of the increasing care of dependent children due to cultural patterns in which they remain in villages and bear and raise children while men migrate. Unfortunately, these cultural and deeply personal dimensions in the patterns of men's

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migration and women's reproduction are too often ignored in current efforts to respond to the spread of HIV/AIDS.

CONTEXTS AND STRUCTURES OF GENDER AND CAREWORK AND THE ADVENT OF AIDS IN BOTSWANA

In Botswana, there is an active, public campaign sponsored by the government and known as the ABCs, intended to prevent and stop the current rapid spread of the HIV virus. "Abstain, Be faithful, and Condomise!" are ubiquitous admonishments—printed on billboards, distributed on pamphlets, and broadcast on the radio in this Southern African country. Despite this seemingly widespread attention, the HIV rates continue to rise, and more and more young adults are dying as a result of the epidemic. In addition, cultural understandings about reproductive health as well as historical patterns of migration and child care result in Tswana women's shouldering the greatest burden of caregiving in the era of AIDS in Botswana. Migration is a central aspect of male gender identity and social support in Tswana communities, while reproduction is key in the construction of women's gender identity. These two facets intersect in the changing nature of care for children in the AIDS era.

A historically stable and democratic government and a relatively strong economy¹ have not protected Botswana from some of the highest incidence and prevalence rates of HIV/AIDS infection worldwide. Clinics, hospitals, and the Ministry of Health estimate that approximately one in five individuals is infected (Joint United Nations Programme on HIV/AIDS 2000; Ministry of Finance and Development Planning 1997), although estimates of one in three in the region are not unrealistic. Without exception, all of the women in my study had a relative or close friend who had died of the HIV/AIDS virus, often a result of a symptomatic illness such as tuberculosis or pneumonia. The increasing death rates as a result of HIV-related illness was a common topic of conversation among women in rural villages as the numbers and the visibility of both those with AIDS and their orphans in need of care increased.

The structures of care in Botswana have changed as a result of these increasing HIV infection rates. Historically, it was not unusual for an older woman to foster children in Botswana (Burman 1996). A daughter would send her children to her mother and even on occasion to the mother of the child's father to provide household assistance and other tasks. The fosterage system provided both children and women with structures of support grounded in reciprocity. Women would receive assistance with household tasks, and children would receive care and training. Today, however, with increasing deaths due to the HIV/AIDS epidemic, greater numbers of children are living with and being supported by women relatives. The fosterage system remains in place but is being stretched to the limit as there are greater numbers of children and fewer older women and resources to take care of

them. The crisis of HIV care has resulted in shifts in responsibilities among women and in their available strategies for care and support. The fosterage system has changed from a reciprocal relationship to one where the purpose is largely the care of AIDS orphans.

THE CASE STUDY

During 1996 and 1997, I interviewed 55 Tswana² women between the ages of 25 and 50 on repeated occasions during a two-year research period in Northern Botswana. This research focused on the connections between infertility and migration in the context of HIV/AIDS and illustrated the importance of childbearing in the construction of gender identity.³ Using a snowball sample, I gathered in-depth life histories for each woman. I was able to focus on a network of women and their interrelationships and experiences with child care. Although the sample was drawn from a rural area and the majority of the Botswana population is rural, my data are not representative of the experiences of women in the more urban areas of the South. One unanticipated result of this research was the observation that the epidemic is having great implications for family patterns and resources for child care.

In this article, I draw on the individual story of Mma Bogadi, a 34-year-old Tswana woman, to illustrate how the broader aspects of migration and reproduction intersect in individual attempts to provide care in the context of HIV. Mma Bogadi, whose name translates as "mother of Bogadi," is one of the women who is a primary caregiver for several children and onto whom these responsibilities have shifted as a result of the HIV epidemic. Mma Bogadi's particular experiences reflect those of many women and highlight some of the most pressing changes in carework in the country. The majority (more than two-thirds) of the women I spoke with were taking care of several children who were not their own biological children, had partners engaged in migration, and were responsible for supporting households. Their lives and that of Mma Bogadi illustrate how the specific issues of migration, reproduction, and the HIV crisis at this individual level are connected to broader issues of gender and carework.

Mma Bogadi, who lives in a rural area with limited amenities, has three children of her own but now cares for her late niece's two children as well. She provides them with clothing, food, and school fees and worries about their health given her niece's death from tuberculosis, a clear indication to Mma Bogadi that her niece was HIV positive. The costs of caring for these children are mounting, and rather than the children assisting her in the household, she worries about her resources and abilities to provide for them. Sitting in her three-room cement block home in a rural village in Northern Botswana, Mma Bogadi watches the five young children living in her household as she works on a portable sewing machine, her main source of income. She tells me that "when you follow the ABCs, you aren't thinking about what will happen if you have to take care of someone else's children." As she said, "Before

you might have one, maybe two children sent to you, they would help you out. . . . Today, you are the ones helping them, and it is not just two—you might get five that you have to support.” As Mma Bogadi points out, the crisis of HIV in Botswana has changed the systems of caregiving for children and women are supporting many more children than they might have in the past.

Networks and systems of support have shifted, and even seemingly reversed, as a result of the HIV/AIDS health crisis. Previously, children would be sent to older women for support, and those women could rely on some remittances and financial support from men migrants, usually their sons and husbands. These remittances varied in amount according to what men could or would send back but in general accounted for less than half of a woman's source of income. As a result of illness, remittances have become more uncommon, and fewer men are actually able to support family members; thus, women today find themselves the primary and unpaid caregivers for children of AIDS victims.

Despite some remittances, support of children by men has historically been rare among the Tswana. Men were the ones primarily involved in migration processes throughout Southern Africa and, as a result, were not the main caregivers in the home. It is important in the cultural construction of men's identity for them to say that in addition to migrating, they have fathered a child; however, financial support and acknowledgment by men for those children has been difficult to obtain for the majority of women in the country (Garey and Townsend 1996; Molokomme 1991).

Mma Bogadi's daughter Onalena has two children whom she raises on her own. She explained, “I worry about what will happen to me, who will care for my children if anything was to happen, my mother is already so overwhelmed”; she has begun to pursue other avenues for child maintenance to receive more money for the family. She said, “Everything has changed. Of course, you would care for your children, you want children, but now you have to think about who else might care for them.” Mma Modise, 49 and caring for three grandchildren and two others from her brother's family, recalled the significance of migration in the construction of men's identity and its interconnectedness with the contemporary HIV/AIDS epidemic. She said,

It was common for men to send back money to women, at least something. . . . Today, things have changed and [women] have to look out for themselves, work to provide for all of these children because the men who have left, they may have families [elsewhere] and maybe they just die.

For Mma Bogadi, Onalena, and others, the lived experience of those changes is directly related to the cultural significance of and interconnectedness between systems of migration and reproduction. Previously unreliable remittances from men are even more unreliable as HIV/AIDS death rates increase and women are faced with greater numbers of children to support.

WOMEN HAVE NO TRIBE: GENDER, MIGRATION, AND CAREGIVING

While child fosterage has long been a part of Tswana culture, so too has the phenomenon of migration, both internal and transnational to other parts of Southern Africa. During much of the latter half of the twentieth century, men of reproductive age (approximately 75 percent of men aged 18 to 40) migrated to other parts of Botswana or to South Africa as part of the diamond and coal mining industries. In addition, men and boys were expected to travel to and maintain the cattle kraals outside of villages and towns. Participation in migration, both within the country and to other parts of the region, was often an important part of the life cycle for men, part of the definition of personhood and often entailing migrating for several years at a time before returning home.

While participation in migration processes is central to men's identity, one result is that women are rendered socially invisible. Ironically and even illogically, because women are the primary caregivers, partly as a result of this male out-migration, there is a Tswana proverb that states that "women have no tribe." This negates any recognition that women and their young children compose the majority of households⁴ and maintain community identity. *Mosadi*, or woman, literally translates as one who stays or remains. By extension, those who stay or remain have no tribe, and by definition, tribes or groups of people in Botswana were nomadic and migration was normative. But as is evident with the advent of the contemporary HIV/AIDS crisis, it has become increasingly the case that those who have remained, the women who are the primary caregivers, are the ones who are responsible for Tswana communities throughout the country. The invisibility of women as reflected in the proverb points to a pervasive cultural gender hierarchy where women are seen as less significant. The advent of the HIV/AIDS crisis, however, shifted greater burdens of care onto women and reinforced many of these gender inequalities (Baylies and Bujra 2000).

In addition to the cultural invisibility associated with women's lack of participation in migration, migrants themselves can act as a vector (Setel 1999, 53), spreading the disease and placing women at further disadvantage. As a result of large out-migration by men mainly from rural areas, women have had to rely on various reproductive strategies (Upton 2001), yet these strategies in turn increase a woman's chances of contracting HIV and being caught in the crisis of care. For example, when Mma Bogadi was pregnant with her second child, she described it as a "sleeping fetus." She explained, "I was pregnant for 14 months. . . . The child was not ready to come out yet; it was just sleeping, resting until the time it was ready." At the time when Mma Bogadi became pregnant, she explained that her husband had been away, working in the southern part of the country, but he had been home prior to that time, approximately 14 months earlier. Mma Bogadi had remained in the village caring for her first child but was concerned about the lack of additional children in the construction of her own identity as a woman. The cultural imperatives

for men to migrate and for women to have children leads to nonmonogamous behaviors and increased vulnerability of women, even as they take on the majority of caregiving in those contexts.

GENDER AND REPRODUCTIVE IDENTITY IN THE CONTEXT OF HIV/AIDS

While strategies such as Mma Bogadi's contribute to the transmission and spread of HIV or other sexually transmitted diseases, they also afford women control over reproductive decision making and the crafting of identities, strategies that are particularly significant when one is faced with fears about infertility and the inability to conceive. These strategies also point to the significance of gendered notions of identity in Tswana life and the subsequent difficulties of HIV prevention policies that fail to take into consideration the significance of reproduction in the lives of women. As Schapera (1959) noted, if a woman was unable to conceive, then it was culturally appropriate for a man to seek a *seantlo*, or surrogate, because child-bearing and reproduction are central aspects in the construction of Tswana personhood and identity. No mention, however, is made of male infertility, and this is evident in my own research as well. Should a couple fail to conceive, men were rarely if ever considered to be infertile, and explanations given for such a condition often point to female culpability and the associated stigma (Upton 1999). Therefore, efforts to control or change reproductive behavior, to insist on condom use, is antithetical to cultural imperatives for reproduction and, most important, undermines women's abilities to control reproductive decision making.

In describing her mother's seemingly long pregnancy, Onalena recognized that

it may have been that their [her mother's and that of the husband who was away] blood did not agree—they weren't going to be able to have a child together, but everyone would have said or expected that it was her blood—her blood [and even her womb] was too hot, too slippery, doing something so his blood [sperm] could not get a hold and became weak.

Weak blood is often given as a reason for infertility, particularly and logically as it is understood to occur as a result of using contraceptives. A man might explain that he felt ill, that he had weak blood and had been "bitten" by a woman if he suspected that she was using an oral contraceptive or even that he had been made ill by the lubricants on condoms (Upton 2001). Culturally appropriate explanations and reproductive strategies, particularly those that are crafted as a result of male out-migration (such as extramarital relations), play a large part in women's control over their own status as persons. At the same time, however, they place women at greater risk of infection and ultimately the greater burden of caregiving.

In much the same manner, more recent cultural explanations for HIV/AIDS reflect a perception of HIV as largely a female reproductive disorder and one

fostered by the use of contraceptives. Men who feel bitten by the disease also explain it as a result of having had intercourse with a woman who was ill who had "weak blood."⁵ An even more alarming perception has been that if a man feels his blood to be weakened, an efficacious cure lies in having sexual intercourse with young girls who are virgins, notably without the use of contraceptive protections.

For men who migrate, then, the risk of HIV infection and transmission is high, and eventually, by extension, the risk to women is high. While this is certainly not a new observation, what is significant is that many of the educational materials aimed at HIV/AIDS prevention may not be reaching these men on the move or adequately addressing the intertwined cultural imperatives for men and women to have children. The questions become, Who are the ABCs aimed at? How culturally appropriate are they if the impetus to have a child to be considered an adult person remains socially significant? How are they to be acted on if condomizing, while intended to protect one from illness, may in fact be understood as contributing directly to it? Responses to the HIV/AIDS crisis have primarily focused on the visible need to care for orphaned or sick children (Guest 2001). However, the less visible but culturally important elements of male and female identity, migration and reproduction, have contributed greatly to the current crisis of care.

RESPONSES TO THE HIV/AIDS CRISIS: INVISIBLE WOMEN AND VISIBLE PROBLEMS

Public and global attention to the HIV/AIDS crisis in Botswana is high and has rapidly increased in recent years as both governmental and international aid agencies have donated large sums of money to increasing awareness and family planning programs.⁶ Much of the foci of these initiatives center on educating youth about HIV and reinforcing the need to use condoms and other barrier methods of protection. The problem of AIDS in Botswana is increasingly visible, yet for many Tswana individuals, AIDS remains a "radio disease," something ubiquitous in advertising ("Everyone knows what the ABCs are; you even hear about on the radio," Onalena says) but not necessarily in the forefront of individual practices.

Government and international aid agencies recognize the growing HIV/AIDS crisis with initiatives aimed at educating people about the disease and the importance of using condoms. However, no agency has recognized the actual crisis of care and the role of women's caregiving as key elements in this context. One facet of the growing crisis of care that has garnered public awareness as a result of the AIDS epidemic is the care of dependent children. In addition to the active, visible campaigns supported by the government for education about HIV/AIDS, orphanages, largely supported by international religious organizations have sprung up in answer to this issue. In Mma Bogadi's village, for example, the Lutheran church has established an orphanage, in some sense formalizing the fosterage system in the AIDS era and attempting to address the problem of these dependent children. Less

attention is given to the plight of the women who are actually caring for these children and the cultural factors that have contributed to the rise of this crisis of care. Caring for AIDS orphans is just one aspect of the growing crisis, one that highlights gender inequalities and shifting responsibilities for care.

The cultural allegation that women have no tribe reflects a larger structure of gender inequality in Botswana. This gender hierarchy, which has rendered women socially invisible despite their maintenance of children, has become reinforced in the recent HIV/AIDS era. By focusing on preventing further infection, visible, educational campaigns that emphasize abstinence, being faithful, and condomizing ignore the less visible, cultural, and gendered significance of women's reproduction and the role of men's migration in Tswana society. Both these strategies place women at increased risk for HIV infection.

In addition, while traditional fosterage systems afforded both women and children structures of support, in an era of increasing HIV infections, those systems have become undermined, and women now shoulder the greatest responsibilities in caring for the increasing numbers of children and individuals affected by the HIV/AIDS epidemic. With respect to the Tswana proverb, in the face of the current epidemic, women have even less of a tribe as their health and systems of support diminish. As the current crisis of care in Botswana continues to escalate, gender and carework, as they are related to cultural systems of migration and identity, are changing. Only through culturally appropriate means of prevention, however, where women's roles as caregivers and the centrality of reproduction are recognized in context, will the HIV/AIDS crisis begin to be successfully redressed.

NOTES

1. Botswana remains one of the wealthiest countries in all of sub-Saharan Africa largely due to the diamond mining industry and export of beef cattle to the West.

2. While there are various ethnic groups in the country of Botswana, all of the individuals in this study primarily identified themselves more generally as Tswana and spoke the national language SeTswana.

3. I conducted more recent research on the explicit connections between HIV/AIDS and infertility during 1998, 2001, and 2002.

4. The Botswana government and the National Development Plan estimate that approximately 44 percent of households are headed by women.

5. Weak blood can also occur if a woman transgresses certain taboos, particularly sexually linked ones. For example, a woman who is in mourning should abstain from sex for a certain length of time, most commonly one year. If she has intercourse with a man during that period, he will be stricken with *boswagadi*, or widow's disease, and will complain of becoming sick with weak blood as a result.

6. The Botswana government has created an AIDS unit within the Ministry of Health, and agencies such as Joint United Nations Programme on HIV/AIDS, the World Health Organization, the Centers for Disease Control, and others have invested in AIDS prevention programs throughout the country. Most recently, the Bill and Melinda Gates Foundation has contributed enormous amounts of money to the country in an effort to stem the spread of, and educate people about, HIV.

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