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“There is no care here”: The Conflictual Ethics of Kin and Bureaucratic Care in Botswana

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“There is no care here”: The Conflictual Ethics of Kin and Bureaucratic Care in Botswana

By

Arielle J. Wright

A dissertation presented to
The Graduate School
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

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Arielle Wright

Washington University in St. Louis

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Abstract of the Dissertation
“There is no care here”: The Conflictual Ethics of Kin and Bureaucratic Care in Botswana
by
Arielle J. Wright
Doctor of Philosophy in Anthropology
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Professor Rebecca Lester, Chair

How do people make sense of “care” when it fails? My dissertation examines the ethical debates that are provoked by the limitations of care in the setting of home-based care and associated safety net programs in Botswana. The organization of care is negotiated across domestic and public domains, often incorporating concerns about kinship ties, dependency, and labor in the welfare state. Based on 16 months of ethnographic research, I demonstrate that the ethical evaluation of care varies between differently-positioned stakeholders engaged in providing chronic care. Economic conditions and socio-political ideologies shape the ethics of care by way of setting the circumstances in which it may be achieved, and providing rationales to explain when it cannot. In Botswana’s welfare apparatus, caregiving practice as central to the claims for resources made by caregivers from both kin and government sources. Yet the strategies used by caregivers to secure resources for care and survival are not well recognized by government policy, which employs outdated logics of productive labor and authorized dependency. The concept of “conflictual ethics” provides an analytical tool to examine the conflicts around legitimate dependency that shape the problem of care within a setting of economic precarity. My analysis of the competing ethical frames at play provides important insight for scholarship addressing the relation of care to the ethics of justice, economic inequality, and governance within everyday life.
Chapter 1: Introduction

Rra Tshweu lost his vision when he was 86 years old, and his wife Mma Tshweu (aged 70 years old) took charge of his care. Due to her age and frailty however, she was not able to do so alone; they lived with three adult granddaughters, and their great-grandchildren, who helped with food preparation and domestic tasks. I met the couple and their granddaughters early on a hot morning in Botswana’s dry season, staying cool on a blanket in the shade of a large tree. As I sat with the couple, the young women gathered to listen in and participate as well. I was surprised by the wife’s response when I asked her to define care. “There is no proper care here” she told me. I asked her to explain what she meant by this, and she called on one of her granddaughters to help elaborate. The young woman, Mpho, told me, “To give him proper care, we would need a house where he could sleep. He needs a comfortable environment. At the moment, the house where he sleeps is full of grand and great-grandchildren, clothes, and utensils.” Rra and Mma Tshweu had built a modest single-room house, made of cinderblocks that had not yet been plastered, but the number of residents had outgrown the capacity of the house, prompting Mpho’s appeal.

This encounter was only one of many in which my interlocutors described the routine challenges they faced that negated their ability to provide proper care. As Mpho indicates, housing was one of the concrete ways in which Batswana experience and describe the limits of care. In fact, Mpho and her grandparents had been seeking aid with housing for months by the time I met them. They wanted to be registered for the President’s Housing Appeal, a recent initiative of President Khama that raised funds from private businesses to provide small homes for destitute families. They had repeatedly approached the councilor for their area of the village,

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1 All names have been changed to pseudonyms.
2 Batswana is the plural term for citizens of Botswana, the singular form is Mostwana.
who represented them at the District Council (village level) to sign them up for the program. As Mpho put it, “We have been pleading and crying to the [district] Counselor for the old man to be helped.” Her grandmother added, “We are just lost in the mist. We have been to the kgotla [community gathering] meetings and told the Counselor and Kgosi [sub-chief] about the shelter for the old man, but they do nothing.” Their efforts, which were stymied by a lack of response from local government officials, also indicate a crucial tension that I explore in the dissertation. Specifically, the definition and rationales of “failed care” may differ between kin and those outside the household. Given that the women had a basic shelter and were still able to feed and bathe the old man, they were low priority for the officers in the area – in many ways they continued to “succeed” at providing care, even in challenging circumstances. Such conflicting perspectives inform my analysis of the ethics of care in contemporary Botswana.

Mpho’s story, as well as the design of the Housing Appeal, do corroborate a basic facet of care, however; the achievement of care is rooted in one’s basic material circumstance. Living conditions and basic needs were common themes among my interlocutors. As people struggle to provide care, they are also struggling to navigate poverty more broadly. Caregivers evaluate the challenges of poverty through the lens of their caring efforts, which also offers them a domain in which they can legitimately appeal for needed resources. These were pervasive dynamics in my ethnographic study of home-based caregiving in Serowe, Botswana, which I conducted over a period of 18 months between 2012 - 2017. Mma and Rra Tshweu were one of 136 households that I visited through the village Community Home-based Care (CHBC) program in Serowe.

The national government implemented CHBC in 1996 as a direct response to the illness and mortality caused by the HIV and AIDS crisis (Ministry of Health 1996). The ministry of health eventually expanded CHBC to include patients with diverse conditions who require full-
time care at home, such as physical disability, stroke complications, and cancer. The program connects local volunteers with registered families to help with the routine labor of care and occasionally provide nursing materials such as diapers and disposable gloves. I initially undertook the research with the goal of understanding how programs like CHBC contribute to the social organization of and responsibility for caregiving in the wake of the HIV crisis. As the research went on, however, my scope widened to examine caring relations both within households and between state agents and citizens. This also led to my examination of the significant anxieties and contradictions about the contemporary practice and ethics of care in Botswana.

**Research Questions**

Periods of rapid social change, such as the HIV epidemic in Botswana, de-stabilize and create new uncertainties in previous systems of meaning and practice. In this context, I examine the negotiations around dependency, care, and responsibility that this destabilization created. My engagement with the shifting and uncertain role and expectations of care in this broader social context leads into the fundamental problematic of the dissertation research, which I refer to as the “problem” or failure of care. As I alluded to in the opening vignette, it was common for my interlocutors to tell me that they did not experience or provide proper care due to specific material limitations or the absence of key supporting relations.

Emerging anthropological literature notes that the presence of care is not an automatic feature of social life and may be encountered as a limitation within relational networks (Han 2012; Biehl 2012). This tension may be further heightened in times of transformation because care practices are central to navigating both stability and social change within interpersonal relations (Thelen 2015). I engage with this central tension as both a material and an ethical problem for Batswana. I attend to the narratives and rationales that my interlocutors employ to
define the problem of care in relation to their values, ideals, and the material setting of subsistence. In doing so, I trace key anxieties that surround the practice of care in Botswana; for example, the debates emerging in the wake of HIV and increased orphanhood that articulate concerns about love, neglect, and exploitation within domestic relations (Dahl 2009; Livingston 2006). Related to such concerns are the anxieties of bureaucrats about how dysfunctional relationships within the domestic domain feed irresponsibility and a culture of dependency on welfare aid.

These anxieties led me to the contradictions surrounding care that I explore from various perspectives in the following chapters. I explore this central tension with two related research questions:

1) What kinds of experiences and practical realities inform the contention among many caregivers that care has become problematic or limited?

2) How does this "problem" of care, and the way it is understood by various stakeholders, reflect different interpretations of Botswana's welfare state and its moral obligations to its citizens?

I use these primary questions to orient my analysis around the limits of care and contradictions that emerge between ethics and practice.

**Anthropology of Care**

My research emerges from recent anthropological engagement with the study of care and related topics. For instance, scholars have examined care and shifts in demographic and aging populations (Buch 2015), survival strategies in times of precarity (Han 2012; Garcia 2010), production of social ties in situations of mobility, migrant labor, and social change (Thelen 2015; Drotbohm 2015), the institutional response to epidemics (D. Fassin 2007; Dahl 2014; Stevenson 2014), and humanitarian responses to trauma and displaced populations (M. I. Ticktin 2011;
James 2010). These engagements reflect shifting priorities within scholarship and responds to
calls to reclaim and bring attention to invisible or hidden labor of women, which previously did
not qualify as a legitimate topic of study (Gilligan 1982). As scholars engage with care, they
draw on diverse theories and ethnographic settings, thus the concept of care is shifting, not
uniformly theorized, and unstable (Aulino 2016). Scholarship on care remains “fragmented”
(Thelen 2015, 497). For instance, authors variously refer to the concept to describe everyday
practices and affective sensibilities (Aulino 2016), biomedicine and biopolitics, moral experience
(Kleinman 2013), and exploitation and social inequality (Sufrin 2017; Hochschild 2000).
Medical anthropologists have focused their analyses on the relation of care to technologies of the
self, health care professionalization, and biopolitical regimes (Mol 2008; Stevenson 2014).

I navigate this web of meanings and frameworks regarding care with an embedded
ethnographic approach that builds a concept of care first and foremost from the representations
and experiences of my interlocutors. Using this empirical approach, I define care as a relational
practice comprising emotional and physical labors that maintain the foundational requirements of
personhood and thus express the ethical precepts of social membership and harmonious
interpersonal relations. In many ways, this definition complements existing scholarship on care.
Specifically, it reflects the duality of care as both affective practice (caring about) and practical
action (caring for), which above all is a form of relational labor (Held 2005; Buch 2015). Aulino
(2016) warns, however, against an over-emphasis on care as an “internal conviction” that aligns
outward actions with inner states and “sincere” emotions (92). My interlocutors reveal that the
emotional task of caregiving is as much about restraint (preventing or avoiding internal states
like anger) as about the presence of sentiments like love and patience. I ground their narratives in
both the local ethics of permeable bodies (Livingston 2008) and broader public anxieties about
the insincerity of relatives (Dahl 2009, 2016). I prioritize the descriptions and practices of caregivers to avoid an over-determination of care and to highlight the local contours in meaning, as well as the significant realms of tension and debate that characterize the practice of care in Botswana.

My emphasis on the local specificity of care also helps define the connection between care as a relational practice and the concrete material labors and modes of resource distribution that sustain it. Although care is not purely determined by economic conditions, these are crucial to our understanding of the work of care (Aulino 2016). Ethnographers have approached this challenge through the translation of political-economic forces into everyday relations and domestic arrangements (Han 2012; Buch 2015). As people navigate the task of care in an interpersonal domain, they are also navigating the larger institutional frameworks that aid or impede it. For this reason, caregiving is an important lens for understanding forms and effects of governance (Buch 2015). I trace the sources of various resources necessary for care, which quickly made it apparent that the domestic space of caregiving was not cut off from broader policy arrangements. in fact, household care was embedded within wider social networks and the local safety net.

My research also engages with scholarship on care as a “given element” of kinship (Thelen 2015, 498), which is assumed to be a social good in decline (Dahl 2009; Klaits 2010). Anthropologists of kinship have demonstrated the importance of caring acts like nurturing and sharing to the constitution (rather than as consequence) of kinship relations (Carsten 1995; Franklin and Ragone 1998). In fact, Borneman (2001) proposed that care should replace the primacy of descent and alliance as the foundational principle of kinship studies. This trend has divided scholarly attention to distinct domains; paid or institutional care, and household care
respectively, which replicates a public-private binary in studies of care (Thelen 2015). This division has deep roots that go back to Marxist anthropology that conceptualized care in terms of women’s unpaid social reproduction, which sustained the labor force and male public production (ibid). Even the institutionalization of care follows this distinction, as professional care is feminized, low-paid and non-skilled compared to men’s work (England 2005).

Thelen (2015) proposes, conversely, that we can overcome such limiting dichotomies if we theorize care as a central element of social organization. I do so by demonstrating the role of care in constituting or dissolving relations across different fields of action (e.g. domestic and public care). I foreground how the circulation of care brings actors across domains into relation, as well as when the blockage or denial of care disconnects these relations. This demonstrates how care practices connect the basic needs of human bodies to everyday labors, interpersonal relations, household formation, and state agencies. The chapters in the dissertation follow a concentric model, which moves from the intimate realm of the household outward to extended kin networks and the officers of the local government. Rather than frame this model as a contrast between the intimate (domestic) and impersonal (state governance) domains, I aim to demonstrate these concentric rings are mutually constituted.

I take care as my analytic object precisely because it allows me to move across these scales and domains. In relating domestic care to political formations, I place processes of care at the center of societal negotiations of what represents “legitimate need” and “deserving” recipients of care (Thelen 2015, 505). The negotiation of legitimate need emerges from conflicting ideas and values surrounding care and deservingness amongst generations, genders, and social classes within society. The dialogue around need and access to care that I uncovered in Botswana revolves around a contested concept of dependency. Some Batswana echo restricted
models of dependency, in which care applies to the “other” of the (male) autonomous laborer; such as the elderly, the sick, children, and those with disabilities (Ferguson 2015). Yet this is not a monolithic ideal; in practice, it exists alongside ethical formulations of mutual personhood (Durham and Klaits 2002), and the material realities of subsistence. Moreover, my household data supports existing scholarship on the reality that “interdependence rather than independence characterizes the lives of all humans” (Thelen 2015, 510).

Local values encompass both autonomy (the concept of itirela, doing for oneself) and the values of mutual humanity and respect (botho) and proper behavior or manners (maitseo) based on the connections between people. Not only does proper action toward others demonstrate your own ethical personhood, but negative emotions may do physical harm to the bodies of others, which emphasizes the permeability of bodies and the mutual constitution of persons (Klaits 2010; Livingston 2008). My interlocutors engaged with these values in different settings and for various rhetorical goals around the absence or provision of caring resources. As they reflected on the practice, goals, and limitations of care, they were also contesting and transforming the values of dependency and independence, and their responsibility for one another.

**Care and Power**

In scaling my analysis of care across the interpersonal domestic domain to the wider sphere of local government and welfare programs, I am also interested in examining the relationship of care and power. Although most scholarship on care has historically emphasized its benevolent or virtuous aspects (Biehl 2012); the reality is far more ambivalent in terms of the role of care in biopolitical management and replicating inequality (Stevenson 2014). The ambivalent aspects of care range from the power asymmetry that limits the personal autonomy of the recipient (Watson et al. 2004; Kröger 2009), to the maintenance of unequal raced and gendered labor systems on a societal scale (Dwyer 2013). Scholars have also struggled to parse
the relationship between care and political economy, either framing it as sullied by capitalist relations (Held 2005), or recognizing the constitution of care and intimacy through material relations (Zelizer 2009; Biehl 2012). My research questions dig into these tensions; I explore how the circulation of care (and its interruptions) help to trace the power relations in society. I contextualize the concrete practices of care within the state institutional policies that facilitate or limit them, to focus attention on a “complex network of power relations” between caregivers, institutions, and ideologies (Thelen 2015, 509).

In their attempts to understand care within a field of unequal power relations, scholars have attended to the construction of “need” within forms of political belonging and exclusion (M. I. Ticktin 2011; D. Fassin 2007). Medical anthropologists have exposed the logics of personal responsibility within biomedical interventions that facilitate denial of care and social abandonment (Biehl 2012; Nguyen 2010). My dissertation examines the ethical responses of those who may be motivated by caring ethics but fail to achieve the demands of care in daily life. When care was not present in the lives of my participants, it provoked ethical reflections on personhood and subsistence that challenged simplistic models of “western” autonomy versus indigenous mutuality (Livingston 2008, 294). Scholars of ordinary ethics have demonstrated that “the ethical” is not a separate domain but an innate aspect of speech and action within our interconnected lives (Das 2012; Brodwin 2013). I build upon this insight by illuminating the diversity of ethical framings available to caregivers and state agents to make sense of their inability to provide care.

The Ethics of Care

Anthropologists have convincingly established that caregiving is a key component of moral experience and the pursuit of personal and collective values (Kleinman 2012, 1999). Thus, I approach the analysis of the interrelation of care and political-economic formations through the
lens of the ethics of care. The ethics of care emerged as subset of moral philosophy that asserts the value of caring for and attending to the needs of others (Held 2006). It gained prominence as an alternative to dominant moral theory, which defined ethics in terms of unbiased rationality and the application of abstract rules. Defining care as a domain of ethical practice and value contests these abstractions and situates ethical reasoning and action within a web of connected social relations; it prioritizes concerns about the well-being of specific others (Held 2006, Bubeck 1995). I contribute to the ethics of care as an analytic framework by making room specifically for the debates, tensions, and conflicting rationales provoked by the limitations of care within material constraints.

I rely on the terms ethics and morality to address collective understandings and negotiations of what is right, just, and good within local worlds. Care is a crucial part of these understandings, and often at the center of debates about ethical sensibilities and framings of a “good life” and “good society” (Thelen 2015, 499). This insight offers a productive starting point for ethnographic engagement with caregiving in specific social worlds. Though the ethics of care provides a valuable framework to understand how caregiving intersects with ethical values, it has not been able to address thus far what ethics emerge when caregiving does not meet expressed ideals, or remains partial and problematic.

My research offers several important correctives to existing theories of the ethics of care. First, I demonstrate that economic conditions shape the ethics of care by way of setting the circumstances in which it may (or may not) be achieved. This contributes crucial nuance to debates about economic morality and caregiving, which tends to conceptualize market

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3 While theorists often use “ethics” to signify the set of normative rules that guide judgments and “morality” to indicate a more diffuse set of generally applied values, I have elected to use the terms interchangeably to reflect Das’ (2012, 134) assertion that these distinctions are of little use to represent interpersonal engagement within the “flux” of daily life.
encroachment as a perversion or corrosion of the domain of care (Held 2005). Second, I reveal the contradictory and shifting ethical meanings attached to care that offer a strategic point of critique between citizens, neighbors, and bureaucrats within the material constraints of poverty. These two contributions lead to my third intervention, which is to challenge the tendency of the ethics of care framework to portray care and interdependency as inevitable and naturalized part of social and familial life. I propose that care is a contingent and fraught achievement rather than a forgone conclusion. It is circumscribed by material conditions and connected to competing ethical evaluations of dependency, labor, and development. Caring ethics encompasses multiple and conflicting rationales for its failure depending on the position of the actor.

**Conflictual Ethics of Care**

To address the multiple rationales for the failure of care, I develop a theoretical framework that I call *conflictual ethics*. This framework approaches the study of ethics through the analysis of the discursive framings of events or actions that have already occurred, with a specific focus on the debates and tensions that emerge in these post-hoc accounts between differently positioned individuals. For example, the evaluations of care reflect different priorities between family caregivers and agents of the state, who invoke various concepts such as dignity or self-sufficiency to justify their positions. This lens builds on empirical ethics, in which ethics emerges from everyday activity and its justification and interpretation (Fassin 2008; Brodwin 2013; Das 1999). I employ this approach by attending to the framings among my interlocutors of breached social expectations that surround the provision of care. In unpacking participant narratives, it became clear that my empirical approach must also make room explicitly for divergences and conflicts within the ethical framings at work.

Conflictual ethics offers a distinct approach in that it seeks specifically to examine how the emergence of ethics in everyday life happens within a field of debate and dialogue rather than
as a straightforward realization of shared values. The “problem” of care emerges here as citizens and bureaucrats differ on understandings of necessary dependency, who is deserving of care, and how to administer it. Family caregivers commonly employed distributive strategies to make claims for resources from others. Yet social workers and other state agents failed to recognize this as a legitimate strategy and relied instead on policy and outdated welfare logics of labor to restrict their definition of authorized dependency (Ferguson 2015). Conflictual ethics provides analytical space for the tensions around dependency that emerge within a setting of economic precarity and contingent livelihoods.

Not only does conflictual ethics allow me to unpack the central tension of the problem of care, but it brings into focus broader debates that link concerns about kinship relations to the practice of governance in the welfare state. Questions of care and its limitations, far from being narrow in scope or merely a family problem, raise long-standing questions in social science scholarship. Specifically, they orient us to the contradiction with state welfare systems between the “caretaking” role of the state and simultaneous fears of dependency and overreliance on state aid. Across the globe, this tension has played out in debates around family structure and the culture of poverty (Greenbaum 2015), development values and practice (Escobar 1991), and the role of the state versus private sector to mitigate poverty and provide care (Ferguson 2015). I contribute to these discussions by demonstrating how conflictual ethics support logics of governance that maintain social arrangements of poverty. I reveal the flexibility of ethical rationales surrounding poverty and vulnerability by examining how the representatives of the state grapple with notions of care while also justifying the denial of aid.

The debates embedded in the conflictual ethics of care relate to larger questions of poverty and we owe to each other and what our government owes to us. What is surprising is the
ways in which blaming the poor for dependency operates even within bureaucratic logics aimed at “caring” for citizens. Through this lens, I examine the ways in which caring reflects certain key values yet is qualified and often contingent, and never a complete or monolithic process. Thus, does care (and its ethics) emerge within a realm of push-and-pull between different values and material conditions. Hierarchy, social belonging, and care have a long and intertwined history in Botswana, and southern Africa more broadly (Ferguson 2015). These processes exist in uneasy tension in contemporary governance, which directly informs the shape of ethics at the intersection of domestic and state relations.

**Research Design**

During 18 months of research within Community Home-Based Care (CHBC) and associated social safety net programs in the central district of Botswana, I used mixed methods including surveys, interviews, and participant observation to address my primary questions. I recruited caregiving households into the study with the aid of CHBC volunteers. I conducted in-person survey questionnaires with 136 family caregivers, which focused on household demographics, residence patterns, economic activities, and food provision. Following the surveys, I used random sampling to return to 10% of my surveyed households to conduct formal in-depth interviews about their subsistence strategies, assessment of their social support network, and experience with government and NGO assistance programs. I also spent time informally within caregiving households and tracked changes within them from the period of 2012 – 2015. Local clinic staff asked me to participate in workshops with their volunteers, and I met and collaborated with informal community associations that ran programs on community health, HIV, disability, and family counselling. These techniques come together in my analysis that balances tensions between material realities and ethical frameworks, and prioritizes the
paradoxes rather than seeking universal values. In the following section, I provide a road map of the dissertation chapters.

**Dissertation Outline**

*Introduction*

In my introduction, I outline general trends and topics in the anthropology of care as well as the position of my research within it. The diversity of settings and theoretical orientations have contributed to a conception of care that is shifting and ambiguous. Thus, care as an analytic object may encompass everyday affects and habitus, medical services, biopolitics and technologies of the self, gendered power relations, welfare reforms, exploitation and social inequality. I outline the fundamental problematic of my research, which I refer to as the “problem” or failure of care and argue this is both a material and an ethical problem for Batswana. I use this central paradox and question to formulate a set of necessary interventions in the anthropology of care.

*Chapter Two*

In chapter two, I establish the ethnographic setting of the research. I contextualize the contemporary setting with a historical review of political, economic, household, and kinship transformations in Botswana. I trace the legacy of Tswana hierarchical and benevolent government from the institutions of the Kgosi (chief) and Kgotla (assembly) to the current paternalist developmental state that cares for its vulnerable citizens. There are clear continuities in the pre- and post-colonial elite class in terms of both democratic leadership positions and wealth in cattle-holdings. Yet there have been significant transformations in the practices of household formation, marriage, and kinship related to Botswana’s longstanding position as a reserve labor pool for mining industries. The extraction of diamonds and commercialization of cattle has contributed to growing GDP, alongside increasing disparities in wealth, land-holding,
and economic opportunities. The ever-growing wealth gap creates tensions between contemporary practices of dependency and historic forms of governance that relied on both hierarchy and benevolent rule. After I establish the social and political context of contemporary domestic and government institutions, I describe my research design and methods. I approach the rich ethnographic data of caregivers’ and bureaucrats’ experience providing care with a mixed-methodology that relies on household survey data, and semi-structured interviews, and participant observation with various actors in the local safety net.

Chapter Three

In chapter three, I attend to the ways that caregivers describe how care is (and should be) practiced and explore the inherently relational context of acts and dispositions of care. I also demonstrate the specific contours of care as an “ethical” domain in Tswana social life, and the notions of personhood, social recognition, and human dignity that animate it. I define care as a relational practice comprising emotional and physical labors that maintain the foundational requirements of personhood and thus express the ethical precepts of social membership and harmonious interpersonal relations. The empirical concept of care that emerges is one that exists in the relationship between individuals rather than in single bodies.

The maintenance of the physical and emotional well-being of a loved one is simultaneously the maintenance of one’s relationship with them, which continually recreates the bonds of kinship. The achievement of such ideal relations of care, however, requires significant material and financial inputs, and interlocutors regularly sought resources from a range of relations (both kin and governmental) to sustain caring practice and survival. There were often setbacks or frustrations in this process; caregivers expressed these in terms of painful feelings and a tension between their ideal of care and the reality of their material circumstances. The
failure of their relations to provide material resources led caregivers to lament the absence of these relatives and their failure to achieve proper care. The gap between the ideals of care and the material possibility of achieving this ideal lie behind the articulation of the “problem” of care among my interlocutors.

Chapter Four

In chapter four, I build from the empirical definition of care to attend in depth to the central tension that emerged among my interlocutors, in which they contrasted the ideal expression of care with the reality of its limitations and short-comings. I shift my focus to a foundational question that animates the dissertation, why did interlocutors often describe care as a failure or problem? To address this tension, I outline common economic realities and relational strategies amongst caregivers, and the struggles that they experience in everyday life, as the context from which their ethical framings emerge. I place their narratives of the limits or absence of care in dialogue with survival strategies so that we can comprehend how ethical breaches of care take shape in their social worlds. I describe the most common patterns of household formation and demonstrate the flexibility of (primarily) female kin relations. Despite the ability of these strategies to mitigate the worst aspects of poverty, caregivers still experienced challenges with the various obligations that they had to shoulder at once.

Caregiving figures most prominently in women’s strategies, but shapes the formation of household residence and subsistence more broadly. It entitles a caregiver to a share of a relative’s income, which also serves to further expand the distribution of state resources like pensions. This produces an interdependency within the household in which caregiving circulates with material resources, which undermines common policy framings of restricted dependency. The material basis of this interdependency comes from a network of key relations, both kin and governmental.
Thus, the “problem” of care is the problem of relations that fail to furnish the distributional flows that have come to define them.

Chapter Five

In chapter five, I shift my lens from the material and demographic basis of household care and survival to the broader institutional safety net that helps to sustain this process. Specifically, I explore the roles and narratives of actors associated with state offices who distribute crucial resources to households and thus play a central role in caregiving practice. I identify these forms of engagement as a specific mode of “bureaucratic care” that connects the government to its citizens. I use the case study of Community-Home Based Care (CHBC) to illustrate how the implementation of the local safety net targets the relational nexus of care, rather than dis-embedding the individual from their social milieu.

Representatives of the state are drawn into (and drawn from) local relational networks and are thus subject to critiques of absent or failed care. I contrast this mode of bureaucratic care with other ethnographic texts that focus on the individualizing models of biomedical or humanitarian care that divorce individuals from their social or relational setting. In doing so, however, I demonstrate that even a relational logic of bureaucratic care entails a specific politics or arrangement of power relations. Specifically, I identify the disciplinary aspects of material transfers within bureaucratic care. Within the caring state in Botswana, both the language and the provision of care (and corollary resources) creates specific power asymmetries between government gatekeepers and citizens. The disciplinary gaze of bureaucrats extends beyond personal responsibility to notions of proper relational and economic subjectivities. I establish this pattern so that the following chapter I can attend to the specific ethical conflicts that it generates surrounding the provision of care.
Chapter Six

In chapter six, I return to the empirical formulations of my interlocutors surrounding the rationales for the failure of care. I attend here to my second research question: how does the "problem" of care reflect different interpretations of Botswana's welfare state and its moral obligations to its citizens? To address this, I employ conflictual ethics to trace the divergent framings of citizens and bureaucrats respectively about breached social expectations of care.

Bureaucrats employed a distinct ethical lens in evaluating the state of care and domestic relations, which emerges from the disciplinary techniques and development values of bureaucratic aid. When citizens challenged or complicated this effort, bureaucrats criticized the “mindset” of citizens and rendered dependency into a problematic tension in governance. This lens reveals significant paradoxes for welfare policy, including a gap between formal logics of dependency and the reality of interdependency in a setting of economic precarity and distributive strategies. The values and logics of development and the modernizing state come into tension with long-standing forms of benevolent political hierarchies that relied on dependency for social membership. I argue that the ethical rationales of bureaucrats, though they ultimately serve to blame the poor for their own predicament, do not simply replicate logics of autonomous workers or nuclear households, but remain caught in the push-and-pull of both autonomous and collective personhood informed by both Tswana cultural logics and integration into the capitalist world system.

Chapter Seven

In chapter seven, I expand the implications of the disciplinary apparatus of bureaucratic care in the context of on-going marginalization of Basarwa people in the village. I outline key parameters of social-economic marginality that have endured for Basarwa over a long historical
period in various forms. Following this, I employ empirical ethics to examine the rationales that emerge to explain the limitations or failures of the welfare apparatus from the points of view of bureaucrats and Basarwa interlocutors. I argue that bureaucrats act from and affirm a hierarchical relation as they deploy welfare care as disciplinary technology, reifying ethnic difference as they attempt to create more disciplined assimilated subjects.

This chapter expands on the paradox of dependency by analyzing the creation (and maintenance) of dependency as a mechanism that attempts to assimilate the “ethnic” difference of Basarwa. I propose that dependency on government aid among Basarwa communities is the continuation of long-standing patronage relations of which “care” is a central aspect, which have never provided for their inclusion or social mobility. Currently, “cultural” narratives interact with ethical justifications to create an essentialist ethnic project. State agents justify the ongoing poverty of Basarwa people in terms of their culture; such as their nomadism, fear of outsiders, ignorance, and immature relation to money. The inability (or resistance) of Basarwa to transform into the hegemonic subjects of the Tswana state reinforces the social construction of difference that masks structural relations of inequality. This analysis contributes to ethnographic engagements with the ambivalence of institutional modes of care marked by asymmetrical power relations in society.

**Research Aims**

My research demonstrates that ethnographic inquiry plays a vital role in scholarly discussions about caregiving and ethics. My intellectual aim is to trace how interlocutors perceive care for the vulnerable to succeed or fail, and in doing so how individuals make sense of these failings, their relations to others, and the role of political agencies. The ethical evaluations provoked by inadequate care are unsettled and differences emerge between the claims made by family caregivers and government agents. Rather than describe the ethics of care as a unifying
social force, I propose that it’s divergences and contradictions illuminate the political potentials of care within systems that (re)produce economic and social inequalities. My analysis of these competing ethical frames provides important empirical insight for questions on the role and relation of care to welfare systems, justice, economic and gender inequality, and poverty in everyday life.
Chapter 2: Ethnographic Setting and Methods

The village of Serowe spreads out from the base of a large rocky outcropping called Tshwaraganyo Hill, where the Bangwato chief first founded a settlement in the early 1800s. The village sits on the eastern periphery of the Kalahari Desert and, given its arid climate, goes through two distinct seasons. The dry season has the coolest temperatures; it stretches from April to October. During these months there is no rain, and the pale brown and yellow of the dry grasses and spindly bushes is only occasionally broken up by a burst of bright green leaves on an evergreen shrub. The change of seasons brings strong winds gusting across the rust-colored earth to pick up plumes of sand with its force. The large, leafy Jacaranda trees begin to bloom shortly before the rains return in October, with bright purple and orange blooms bursting from their top branches. The rains return with the hot temperatures, and provide brief refreshment with their cloud bursts. The rains also bring a resurgence of color; green grass and vegetation seems to appear overnight, flowers blooming on the thorny trees. The village roads are mostly unpaved and, along with the sandy soil, turn to a deep red-brown mud and release a powerful earthy smell when it rains. The effect is the land transformed, which lends itself to the dual meaning of the Tswana term pula, both rain and blessing.

All around the village – even creeping into village limits around its outer edge – is the wilder “bush” land. In the bush, trees are short and dense, many of them sport thorns that are quick to snag clothing. The terrain is open and stretches out; rocky and sandy with a few distant hills reaching up to a wide sky. If you want to access the bush a 4-wheel drive is a necessity -- even trucks are easily stuck in the rainy season, as the tires are swallowed by the mud. Most trees are short enough for goats to rear up on hind legs to eat from the taller branches. The hills that
occur sparsely across the landscape look like great piles of boulders, with large rust-red rocks adorning their top faces.

The village wakes up early, especially in the hotter months of the year, from October to April. Sunrise at 6am finds inhabitants already busy with cooking fires and getting ready for school or work. The early morning provides the only cool part of the day. Morning also brings the full variety of birdsong, quieting again in the heat of the afternoon.

Serowe, although it is large and sprawling, retains the identity of a ‘village’ because it has not seen the amount of commercial and residential development of the capital Gaborone or the nearby mining town of Palapye. Private houses are single-story only, and few commercial offices or buildings rise more than two stories, even in the “main mall” or town center. The main mall is the center of commercial activity, paved with stones and featuring a bank, two grocery chains, clothing, and “Chinese shops” or general stores run by ex-patriate Chinese families. The lanes in between shops are full of Batswana entrepreneurs selling goods as well, including vegetables like cabbage, tomatoes, spinach, and oranges, or selling clothes, belts, shoes, sweets and even a few chip shops with french fries.

The residential areas of the village spread out from Tshwaraganyo Hill and the main mall, and are organized into dikgotla (wards in English), which are made up of clusters of residential yards around a central gathering space called the Kgotla. The yards spread in different directions, navigated by unmarked footpaths that you learn with practice. The fences between yards are made of either dense bushes or simple chain link, and you’re surrounded by your neighbors on all sides. Neighbors are in hollering distance, frequently stop by to chat if they see you at home, and you will have no choice but to listen to the music of whichever neighbor has the best sound system. The village is quiet and peaceful through the week, but starting on Friday
nights you can hear soundtracks from several bars well into the night, with thumping beats that travel long distances. You also have little insulation from the crows of roosters and sounds of chickens around the clock, continuing at intervals throughout the night. The wind blowing, rooster crowing, snatches of conversation from nearby, and music beats merge together as the sonic ambiance of life in the village. This village was my home for 18 months, spread out over 2012, 2015, and 2017, during which time I lived in the same ward near the main mall. Though I resided only in this area during my stays, my household surveys and interviews took me and my interpreter to the far reaches of the village.

I began my investigation with an ethnographic exploration of the Community-Home Based Care (CHBC) program in the village, but the topic expanded during fieldwork to include research on the larger social safety net and recruit care-giving households who did not access CHBC. I chose Serowe for both academic and practical reasons. First, the village occupies a central place in the political history of Botswana; it is home to the Bangwato tribe, and of Sir Seretse Khama, Bangwato kgosi (chief) and first president of Botswana. Therefore, the village is historically associated with this Tswana elite morafe and remains to this day a Botswana Democracy Party (BDP – Khama’s party) stronghold. As the president’s “home town,” Serowe is an especially interesting setting in which to explore the growing inequalities within Tswana society. Second, although some ethnoarchaeological work has been done in Serowe (e.g. Fewster 2006), there is no ethnographic material about the village. This provides an opportunity to expand and connect my research here to scholarship about other regions and merafe.

In this chapter, I review the scholarship and history of Tswana and political practice to outline the concept of Botswana as the “African Miracle” and a “caring state” (Samatar 1999; Leira 1994). I then examine the economic and demographic transformations that allow me to
define and contextualize current household formation. These sections establish the historical and political context that sets the stage for the central question of this dissertation: Why has care become a “problem” for so many Batswana and what are the anxieties and struggles that fuel this claim? Following this historical review, I describe my research study and the methods and ethics of conducting research on care in contemporary Botswana.

The “African Miracle”: A Historical Review

Botswana has pursued a model of public service provision concerned with the welfare of its citizens since independence (Dahl 2016; Klaits 2010). I examine such provision with the concept of the social “safety net,” which I define following Sufrin (2017, 43) as a multifaceted system designed to provide services to the disenfranchised to meet their basic needs. In Botswana, the safety net includes government pensions, food aid programs, public clinics, and the village development apparatus. Given this safety net, prominent critiques about the absence of care from citizens presents a problem at the heart of contemporary relations.

Scholars have called Botswana the “African Miracle” (Livingston 2009; Samatar 1999) for its welfare-led development model, which stands out in the African continent for effective state institutions alongside economic growth. Studies of governance in Africa have generally focused on ineffectual, absent, predatory, or failed states (Blundo and Le Meur 2009; Bayart 1993; Kieh 2007; Muiu and Martin 2009). Botswana is held up in this literature as the exception that proves the rule, due to its centralized government, development-orientation, and absence of structural adjustment policies and foreign debt (Brada 2011; Du Toit 1995; Maundeni 2002). Within this framework, I approach CHBC and associated safety net programs as a regime of care. In doing so, I focus on the processual and lived dimensions of state formation and encounters between state agents and citizens (Aretxaga 2003; Mitchell 2009; Trouillot 2001). This opens analytical space to account for the conflicts and contradictions in state processes, as
well as the difference between the image of the state and its practical workings (Bierschenk and Sardan 2014).

Peters (1994) has proposed that the much-lauded democracy in Botswana emerged from the political continuity of the eight precolonial Tswana states (*morafe*), which were transformed first into a colonial reserve and then into the districts of the nation-state (16). Acemoglu et al. (2002) elaborate that that the strong economic growth in the country is due to three factors: 1) a long process of Tswana state integration, 2) colonial neglect that helped Tswana political institutions persist, 3) governmental representation at independence of the Tswana elite’s interests in cattle and mining industries\(^4\). The rapid economic growth in Botswana, however, often obscures the reality of a growing wealth gap (Samatar 1999). In the following sections, I discuss the formation of the independent state and the systems of inequality it produced.

**Botswana’s Political and Colonial History**

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\(^4\) Economic elites remained in power through the transition to independent rule. They were very interested in “modernizing” the economy and benefited tremendously from the early ranching industry (Samatar 1999).
Despite being a landlocked and ecologically marginal country and one of the poorest countries in the world at the time of independence in 1966, Botswana earned its “miracle” reputation with decades of high economic growth and stable democratic rule (Acemoglu, Johnson, and Robinson 2002). In large part, this poverty was due to the policies of benign neglect by colonial administrators that favored South Africa’s mining and agricultural development (ibid). In fact, Botswana presents somewhat of a “paradox” of capitalist (private ownership) and socialist-style central planning logics, identifying and inducing growth of specific economic sectors. The national government has closely overseen the development of specific sectors --diamonds and beef exports primarily-- through a series of Five-Year plans beginning in 1965 on the eve of independence (A. Murray and Parsons 2016). The Botswana Democratic Party (BDP), initially led by Sir Seretse Khama who became the first president upon independence, has remained in power since then, winning democratic elections held every 5 years. The party is now led by Seretse’s eldest son, President Ian Seretse Khama. The Khamas are also the historic Kgosi (Chiefs) of the Bangwato morafe, who founded Serowe; thus, the village has strong historic ties to the BDP party.

The British established the Protectorate of Bechuanaland in 1885, which was administered primarily from Mafikeng, South Africa. Their goals with the protectorate were simply to maintain order and extract taxes. Over the period of colonial rule, the territory became increasingly dependent on migrant labor to the mines and the Protectorate was little more than a labor pool and impoverished market for the Union of South Africa. Colonial administrators based in the Union encouraged this pattern (Acemoglu et al. 2002). The British ran the Protectorate under the strategy of Indirect Rule that maintained the authority of the Paramount Chiefs of the eight Tswana morafes. The Tswana morafe (chieftancies) are the basis of modern
ethnic group affiliation and their “tribal territories” under colonial law became the districts of the
new nation (ibid).

**Precolonial Tswana Morafe**

Serowe is the main village of the Central district, which is the historical territory of the Bangwato *morafe*. The eight Tswana *merafe* are political formations based on the interaction of two primary institutions; the *Kgosi* and the *Kgotla* public assembly (P. E. Peters 1994, 27). The *Morafe* is usually translated as “tribe” or chiefdom; it is a political unit that gives allegiance to a *Kgosi* (king, chief, or leader) and his decent group, *dikgosi*, the royal family. At the time of the colonial encounter, the *Kgosi* was the centralized authority and source of civil and cosmological order. His power was exercised within a system of representation and consultation via public assembly in the *Kgotla*, a central enclosure that served as chief’s court, ritual ground, and public meeting place (Peters 1994).

During the pre-colonial period, the chief was the ritual head, intermediary to the ancestors, leader in times of peace and war, and allocator of land. The chief was also typically the most wealthy individual in the *morafe* with the largest herd of cattle (Peters 1994). Cattle were the primary form of wealth and social value, and the distribution of cattle was one of the chief’s most important abilities. This has been called the *Mafisa* system (*go fisa* being to lend or borrow), which entailed the lending of cattle in trust from the Kgosi to his client in return for allegiance and tribute (A. Murray and Parsons 2016). *Mafisa* was crucial to the chief’s role as a guardian of the needy, his ability to acquire new clients, and his capacity to arrange for the care of his large herds. *Mafisa* holders could belong to different social ranks, and they were entitled to the milk from the cattle but could not sell or trade it for bridewealth or slaughter (Peters 1994). In fact, this organizational principle spread across the Kalahari in late 18th century, and allowed for conquered groups to be incorporated via *Mafisa* and payment of tribute (Murray and Parsons
In Tswana poems and stories, the chief often took on a heroic dimension; not only was he a hero and controller of wealth, he was often addressed by the name of the *morafe*, the chief was symbolic of the state (Peters 1994).

Due to the policy of Indirect Rule, *dikgosi* (chiefs) saw their powers altered rather than removed under colonial rule. The British colonial administration created the House of Chiefs (like Parliament, but hereditary) but limited their local powers (Acemoglu et al. 2002). Chiefs lost their central role in land and resource allocation, but remained adjudicators in “customary courts” alongside the British Common Law system. Strong Chiefs in the final decades of colonial rule and transition to independence played a role in the development of governance structures that focused on institutional development (*ibid*). By the 1930s, the second generation of chiefs under colonial rule began to lobby the administration for roads, schools, clinic, dams, boreholes, veterinary services, vehicles, and more ploughs (Peters 1994).

The *Morafe* was organizationally centered on the Chief and spatially centered on the town (*Motse*). A *Morafe* was divided into distinct *makgotla* (plural of Kgotla) or wards – and villages still follow this layout. These wards mirrored the larger *morafe*; each had its own *Kgosana* (sub-chief) and *kgotla* assembly to discuss internal affairs. Although the *Morafe* centered on the chief, it was also internally differentiated by rank and wealth (Peters 1994). This was a hierarchical social order, which was held together with the patronage and dependency networks of the *Mafisa* system. Clients of the chiefs would “receive as much milk and food as would be necessary for his support” (Burchell 1953, 248). In return, clients cared for their patron’s cattle, settled in his village, and owed him allegiance. Tswana themselves did not represent rank on a vertical ladder, but as concentric circles with *dikgosi* at the center and power
diffused out among encircling groups. It is more common for Tswana to describe a lower-rank as being “behind” the chief, rather than below him (Peters 1994, 27).

For most residents in the *morafe*, social rank was fluid rather than fixed; families could move between ranks as their wealth and alliances shifted (Peters 1994). This was not the case for all groups, however. The minority Basarwa lived outside the *motse* (village). They were marked by powerful forms of difference because they lived in the “bush” (*mo nageng*) and were stereotyped as being more animalistic and wild (Peters 1994, 25). The relevance of this line of distinction has persisted into contemporary society with formulations of the culturally backward “bushmen,” which will be explored in depth in Chapter seven.

**Post-colonial Development and Rising Inequality**

Chiefly elite class played a central and foundational role in the formation of the Tswana *morafe*, which emanated outward from them in both space and social relations. During Protectorate rule, the British were not concerned with developing infrastructure in the impoverished territory, and it was mainly the small *dikgosi* class who were able to access missionary education and learn English. This same elite class took over the ruling state apparatus at the time of independence in 1966. Not only were they aligned in their class status and education, but most them were large cattle holders. At the time of the first democratic election of the BDP, they used their on-going patronage networks with the rural and village dwellers to their advantage as well-respected chiefly figures and patrons (Parson 1984; Samatar 1999).

While most scholars emphasize the effectiveness of their early governance strategies, Samatar proposes that the hidden dimension of the “African Miracle” is the radical inequality of a growing gap between the rich and the poor promoted by a “growth without equity” model (Samatar 1999, 12). Molutsi (1990) argued that leaders could pursue accumulation by the dominant class because they also cultivated democratic legitimacy with the poor majority. The
BDP maintained the support of the rural population with the strategic use of foreign aid that was spent on water, health, and education for rural populations, while the state used its resources to fuel more private growth. Provision of public services has therefore occurred alongside deepening economic inequality. While foreign aid was allotted to extend “basic social services” to most of the population, there has not been a corollary program to increase opportunities to make a living (Saugestad 2001, 77). Although welfare assistance may modify the worst symptoms of poverty, the population does not have equal access to resources or guaranteed means to secure income at the household level.

A concrete measure of the increasing wealth inequality is reflected in skewed cattle holdings, with the wealthy accumulating vast herds quickly (Good 2008). The accumulation and distribution of cattle was the primary means of wealth accumulation in the pre-colonial period, and was commercialized early on by the elite class (who were already large cattle holders.) As communal lands and water access were privatized (Peters 1994), the wealthy increased their share of total cattle holdings. In 1979, 71% of the poorest cattle owners held only 37% of the livestock holdings. By 1993, even this share had dwindled; 92% of the poorest owners held 34% of cattle, while the wealthiest 2% of cattle owners held 39% of total livestock (Samatar 1999, 113). Despite the worsening wealth gap, the BDP has maintained its legitimacy as a party that cares about citizens. Not only has the BDP extended services like health and electricity across the country, it has also made strategic use of pre-colonial political formations like the Kgotla assembly.

The Institution of the Kgotla

The kgotla system was an essential part of the political authority of Tswana rulers because it provided a space of interaction and accountability. The Tswana proverb “kgosi ke kgosi ka morafe” (the king is the king because of the tribe) was put into practice via kgotla
assemblies. Historically, all adult males could attend and speak during a kgotla meeting, allowing the chief to ascertain the feelings of his people and providing an opportunity to air grievances. The importance of the kgotla to the Tswana conception of democracy is indicated by the survival of this institution through the transition to democratic rule. Acemoglu et al. (2002) proposed that the Kgotla helped to “pave the way to an effective modern state” (196). When I attended an assembly at the main kgotla in Serowe, President Khama addressed the crowd and emphasized the inherently democratic nature of the kgotla and Tswana political life.

After independence in 1966, the kgotla continued to play a central role in the performance of government as a meeting place between newly elected leaders and citizens. First president Seretse Khama and vice president Masire traveled around the country to visit kgotlas to explain, discuss, and justify their new policies and laws. Even the process of building the new capital of Gaborone in the 1960s included building kgotlas to preserve this tradition (Acemoglu et al. 2002). As the powers of the Kgosi have changed, so too has the use of the kgotla. In contemporary settings, the kgotla is now open to participation from both male and female residents, and it serves as the point of delivery for messages from the national and local government. On multiple occasions, I observed local councilors and chiefs share new policies and programs with a crowd during such meetings. My bureaucratic interlocutors repeatedly mentioned that the kgotla is a key space in which they define their relationships to citizens, where they routinely communicate and interact (see Chapter 5).

**Hierarchy and Mutual Dependence in the Tswana State**

This brief overview of Tswana political arrangements before, during, and after colonial rule reveal key legacies for the question of care in the modern state. First, the hierarchical nature of the Morafe polity was one based on patronage networks; commoners owed allegiance and their political belonging to their dependency on the Kgosi, but in return the Kgosi owed them a
basic level of protection and subsistence – a form of power based on the ability to care for one’s people. Second, the formation of independent Botswana preserved the position and wealth of the elites, and it is possible to see the legacy of the benevolent ruler in the current formulation of the welfare state. Yet, throughout colonial and capitalist incursions into the region, the ways in which one makes a living and the social dynamics of hierarchy have also been transformed. In the next section, I examine the political economy of migration and development as they shaped the Tswana household, a key site of the social organization of care.

Modernization, Gender, and Household Formation

The economic history of Southern Africa has been powerfully shaped by migratory labor and mining industries. I discuss Botswana’s integration into this system since Protectorate rule, because this is closely linked to transformations in kinship and household practices in the country. Migration has been a prominent lens through which scholars have addressed social change and explored cycles and shifts in household size and composition over time (Izzard 1985). Labor migration in Botswana includes both male international migration to South Africa and more recent internal wage migration of both men and women to urban centers in Botswana (Murray 1987). Wage migration has been linked to specific changes in local forms of production and reproduction (Klaits 2010). The narrative of Tswana marriage and kinship, for example, has always focused on transformation caused by migration. Beginning with Schapera’s research in the 1920-30s, scholars have documented the impact of colonialism and migrant labor on Tswana domestic and social life (Schapera 2015; Comaroff and Comaroff 1988; Meillassoux 1981; Roberts 1985).

Scholars have used ‘modernization’ as a lens to examine migratory labor patterns and related changes in work and residence; such as the changes caused by large numbers of young men leaving the village for employment. The absence of young wage earners had many
consequences, including a higher demand on older men to continue overseeing agricultural activities and dispersing the physical proximity of families (Brown 1983; Kooijman 1978). Brown (1983) proposes that this dispersal is in part responsible for the reduction of sharing and redistributive measures, even as rural households experienced an increased need for cash. She posits that these redistributive changes are part of a shift from the “family group” of related households to the individual household as the unit of social activity and cooperation (378). Other authors link the process of out-migration among youth to new capitalist logics of personal autonomy that conflict with existing generational hierarchies and communitarian social structures in the village (Durham 2004; Ingstad et al. 1992).

There has also been a great deal of attention paid by scholars to the general trend of increased extramarital cohabitation and childbearing (Comaroff and Roberts 1977), the delay and decline of marriage (Helle-Valle 1999; Klaits 2010; Schapera and Roberts 1975) and the “three-generation” household unit (Gulbrandsen 1986; Kocken and Uhlenbeck 1980; Murray 1987, 243). Scholars have examined the impact of modernization on women’s roles in these processes and their shifting relations with kin members and male partners. Discussions about modernization and women’s changing roles are also connected to concerns about the social order of kinship and its ability to absorb the need for care (Livingston 2003; Ingstad et al. 1992; Ingstad 2004).

**The Emergence of Female Households**

Changing marital and childrearing strategies are cited as features of the emergence of the female-headed household, defined as a pattern of residence in which adult children remain unmarried and “establish their own households based upon the mother-son (or daughter) bond” (Murray 1987, 243; Gulbrandsen 1986). Schapera (2015, 1966) noted few households run by women independent of a male guardian in the 1930s. At the end of the 1970s, however, national
surveys recorded a female head of household rate ranging from 20 - 42% across the country (Peters 1983). In 1978, 36% of households in Tlokweng village (near the capitol) had three generations. Young unmarried women still contributed to households either in domestic labor or wage remittances and 52% of them worked away from the household but left their children behind as dependents (Kocken and Uhlenbeck 1980; Brown 1983). These trends have persisted; according to the data I collected, 60.3% of my participant households were female-headed, and 56% included three or more generations in the residential unit.

These changing strategies have led scholars to question whether family structure in Botswana can now be described as ‘matrifocal.’ Izzard (1985, 266) and Peters (1983) propose that the term can be used to identify the dominant role of the mother and maternal kin in raising children coupled with the marginalization of the father. Research in the 1970s linked the absence of men to an increased likelihood of poverty, smaller harvest, and absence of labor leading to flows of inherited disadvantage along the “matrifocal chain” (Peters 1983, 114). Similarly, female headed households were presented as deviations from the “nuclear family household” paradigm thought to buttress male migrant labor, and seen “as evidence of 'breakdown' of a 'normal' pattern of household” (Murray 1987, 243).

In Botswana, the label of ‘breakdown’ is misleading, however, since marital changes represent a reorientation toward the natal family rather than a breakdown in social relations altogether. Nor does the three-generation household structure necessarily mean that men are marginal to women’s household strategies. Female household heads, for example, still derive support from men in diverse relations. Brown (1983) specifically points out that remaining unmarried does not preclude relations with the children’s father or his family and may look for resources from brothers and male kinsmen. Halle-Valle argues that women also engage in
“economically advantageous” and informal sexual relationships (1999, 373). They represent a substantial economic exchange between men to women, but do not entail the legal right of the man to children or control over a woman’s domestic practices.

**Conceptualizing the Tswana Household**

A number of these historical tensions and themes are relevant to my research. In terms of household formation, my interlocutors echo scholarly concerns of the ‘narrowing’ of kin cooperation. While domestic units continued to operate around three generations in many cases, my interlocutors observed on-going tensions within their wider field of relations such as siblings, cousins, or nieces and nephews. Their concerns about the state of broader family relations resonate with scholarly questions over the role of male kin and changing foundations of household formation. I will explore these household strategies in depth in Chapter 4, but I first establish my framework for household studies in Serowe.

Gendered labor, both care-giving and wage-earning, is central to the maintenance of relationships that constitute a household (Guyer and Peters 1987). Feminist scholars have critiqued the notion of the household as a homogenous egalitarian unit (Izzard 1985; D. Thomas 1990). In fact, caring labor is organized within gendered and generational roles and hierarchies that internally differentiate the household (Clark 1993; Urdang 2006). I employ this lens by conceptualizing the ‘household’ as an internally-differentiated and flexible unit of cohabitation and cooperation, following cycles of mobility, expansion, and contraction over time. In Botswana, scholars have long recognized that a familial group with several “residentially separate sub-units” could share a household strategy over time (Izzard 1985: 262). According to my interlocutors, the densest relations of interdependency and reciprocity continued to focus on those who lived full-time in the same yard. Almost half of surveyed households (46%) however,
included part-time residents who lived elsewhere but regularly returned to visit and continued to contribute resources to the household.

The concept of “the household” remains relevant for my research because it offers a lens to understand the ways in which groups of people remain engaged in each other’s survival and livelihoods. In Serowe, the spatial unit of the household is the lolwapa (homestead). The homestead is a large yard bounded on the exterior with fencing, ranging from thorn bushes, to chain link, to “security walls” made of concrete. Within the yard, the dwellings are decentralized, composed of multiple rooms built around a courtyard area. Most are single rooms, built from concrete and covered with plaster, though some remain the historical mud-and-thatch style hut called a rondavel. The simplest yards have several rooms for sleeping with an outdoor “kitchen” area for their cooking fire and a simple storeroom and outhouse. Families with financial means increasingly opt to build a single multi-room house with a kitchen and indoor bathroom. The lolwapa usually represents a single household, with all residents cooperating financially though they might sleep in different rooms. In a small number of homesteads (5%), I found divisions or tensions (usually between siblings) that had resulted in a “divided” yard, but this was the exception rather than the rule. In Chapter 4, I offer a detailed examination of the patterns of cohabitation and kin relations that constitute the diversity of households in my sample.

**Household Survival and Care Practices**

Care is central to discussions about the Tswana household because scholars have linked modernization to the breakdown of exchanges and responsibilities for care in the household (Livingston 2003, 2006; Ingstad 2004). Historically caregiving is the domain of the family, many Batswana return to the village to retire or to be cared for when they are ill (Ingstad et al. 1992). It was this responsibility that strained households during the early years of the HIV epidemic. Women are key to this domestic arrangement of care, but they also increasingly migrate to earn
wages to support their own children when they reach working age. Grandmothers and elder women are not only recipients of care, but often play an essential role as surrogate mothers to their grandchildren while they daughters work (Izzard 1985).

These networks of obligation to give and rights to receive care have been described as a moral economy of care (Livingston 2005). This economy is centered around the interdependence of mother and daughter, and these arrangements are flexible and durable as a survival strategy. A woman initially pursues employment that satisfies “her responsibilities towards her mother and her offspring” until the time that the next generation (especially her daughters) can migrate to support her (Izzard 1985, 275). It allows women to earn a wage in urban areas but maintain strong links to the village (Izzard 1985). Additionally, older women receive financial support to assist with subsistence agriculture and children are raised in the village environment (Ingstad 1992). Children are therefore crucial to the “long-term security” of Batswana women (ibid, 390).

The expectations and obligations that structure moral economies of care occur along gendered lines. For example, in Botswana “motherly love” is infused with a special potency as it comes from a woman’s heart, which makes women central figures in nursing care in the home (Livingston 2005, 98). Motherhood is highly valued as a status for women; as mothers, women have attributes and dispositions that make them natural care-givers. Motherhood is central to the moral economy of care in Botswana because mothering norms reinforce the importance of childrearing and nursing care for women’s status (Livingston 2008). Women have access to authoritative status through care because it aligns with expected roles and skills.

In an ideal economy of care, a mother who cares for her children is later rewarded with care by her daughters in her senescence. The HIV epidemic disrupted this exchange because it disproportionately infected working-age adults and thus erased the incomes streams of these
household members (Livingston 2005). Women’s responsibilities and capacities in the care economy have been strained by the AIDS epidemic (Steinberg 2002; Urdang 2006). Care for HIV patients by grandmothers in the village is not a new pattern of care, since older women were already central to the care economy. The epidemic, however, added to women’s burden with an increased demand for their nursing care while removing the resource of an income-earning child (Ingstad 2004). With the impact of HIV and AIDS, caregiving within the family has taken on special importance.

This imbalance in the care economy has important social repercussions; it is shameful for an elder to be improperly cared for, a dynamic that I investigate in Chapter 3. The role of men in these economies of care is less well-developed in the literature. They are primarily described in terms of their obligation to remit wages to their mothers and in their role as uncle to sisters’ children while they appear to be socially and economically marginalized in their role as fathers (Izzard 1985). My participant population corroborates the on-going steep gender imbalance in caring obligations, but it does reveal that in a small subset of cases, men do play an active role in caring for parents or spouses. Overall, 77% of households had a female primary caregiver, while only 9% of them had a male as the primary caregiver. In 14% of households, these duties were shared by male and female members.

**HIV and the Crisis of Care**

Botswana has the third highest HIV prevalence rate in the world; it is currently estimated to be 21.9% among adults ages 15 - 49. The country still has 10,000 new infections per year for a population of roughly 2 million (“Country Factsheet: Botswana” 2016). The HIV epidemic precipitated a profound decline in adult health indicators in Botswana over the last four decades. While life expectancy climbed and mortality rates dropped 20% between 1970 and 1980, both male and female life expectancy declined (61% and 51% respectively) between 1980 and 1997.
Gains in life expectancy after independence were erased and life expectancy for men and women in 2002 was about 20 years less than in 1970. Between 1970 and 2002 the female adult mortality rate increased 100%. In 2003, the WHO reported that out of 330,000 adults living with HIV, 190,000 were women (Hemson 2010). Currently, the government provides a free ART program for citizens, while also coping with increasing rates of morbidity and mortality due to non-communicable chronic conditions among adults over 45, including hypertension, diabetes and cancer (Harden et al. 2006).

The prevalence of HIV and the ubiquity of severe illness within family networks have brought the ethics of love and care, and the ability of kin networks and health facilities to provide it, to the forefront of public concern in contemporary Botswana (Dahl 2009; Klaits 2010). Livingston (2005) suggests that care in Botswana is a process that unites responsibilities, sentiments, and actions, and Klaits (2010, 4) defines care as both “an act of provision” and a matter of compassionate feeling. Livingston proposes that caregiving practices, including nursing, childcare, visiting, and material support, are imbued with a “moral valence” (2005, 177). Caring sentiments become ethically loaded because they create “mutuality,” or shared bodily and emotional dispositions between persons, and must be carefully managed in order to positively (rather than adversely) affect the physical well-being of others (Durham and Klaits 2002). I examine how these sensibilities shape the definition of care among my participants in the next chapter.

The increased demand for chronic care in Botswana and the resulting strain on women in household networks creates a local world in which the future of kin relations and the moral order of society are threatened. The impact of HIV on the moral and social order has created lasting anxieties about the dissolution of social bonds. For instance, the government orphan food basket
program (a monthly subsidy for food staples) caused concern among Batswana about the state of “cultural safety nets” because it encouraged kin to house orphans only for the material benefit of government aid (Dahl 2014, 633). Similarly, many elders perceived that the introduction of the national old age pension led to a reduction in support and food provided by juniors, weakening kinship ties (Livingston 2005).

Government messages capitalized on these fears to encourage participation in the CHBC program in the late 1990s. In their calls for volunteers, the messages reiterated that HIV was a threat to the nation. The ministry of Health began recruiting volunteers for CHBC in 1996, after which they were trained to assist families in their homes with nursing activities like bathing, dressing wounds, and making the patient comfortable (Odek and Oloo 2007). In order to justify the program, the state appealed to the model of the family as the traditional caring unit in Botswana and to narratives of the Tswana extended family (Browning 2009; Ministry of Health 1996). Yet my pilot research indicated that the program contributed to significant renegotiations around the responsibility and privacy of nursing the sick, as I explore further in Chapter 5.

At the outset of the research, I conducted my study within CHBC to explore how caregivers manage care and subsistence strategies and examine the impact of sending volunteers to assist with this process. The central tension emerged (unexpectedly) during the research that despite all the inputs, caregiver viewed care as problematic and limited. In the follow section, I outline my design and methods, along with the ethical considerations of the research.

**Study Design and Methods**

I employed a mix-methods approach to answer my research question about the tensions between ideals and realities of care-giving in their material context. I drew from both household survey interviews with caregiving families and semi-structured interviews with various actors in CHBC and the village social safety net apparatus. My primary participant populations were
household caregivers, home-based care volunteers, nurses, NGO workers, and government officers, including social workers, development officers, and district councilors. The main body of data collection in 2015 occurred over 14 months and proceeded in two phases.

The first phase entailed collecting household surveys across the village. Although I estimated from pilot research that there would be 80 households registered in CHBC, I used word of mouth and referrals from CHBC volunteers to expand the survey to 136 households. 60% of these households were formally registered in CHBC, and 40% were not, although they were engaged in full-time care and referred to me by volunteers. I expanded the household populations to provide comparative perspectives between those formally registered and those who were not. The survey included questions on household residence, composition, employment, receipt of food aid, occurrence of food shortages, the organization of caring labor in the home, and lasted 45 – 60 minutes. During the survey phase, my research assistant and I visited 136 households across all 6 public clinic catchment areas. The surveys differed in number at various clinics due to the variance in the number of families that the volunteers visited. I visited an average of 22 households at each clinic; with the highest number, 34 households, in the north-west of the village through Kadimo Clinic. The lowest number of households, 14, was in the south-west region at Boipelego clinic. This reflects both greater population density in the north-west, as well as higher levels of impoverishment (see Chapter 7).

During the next phase of the research, I conducted semi-structured interviews with 45 participants across my research populations. After conducting the surveys, I used random number generation to select 14 households (10% of the overall sample) to serve as case studies for follow-up interviews. I contacted family caregivers directly (we had previously obtained their permission to contact them again) to schedule an interview. We met them in their own yards. The
semi-structured interview explored topics relating to their experience of caregiving, subsistence, and CHBC in more depth, and I recorded the audio of interviews, which I then transcribed and translated. Through these interviews I identified the civic, non-governmental, or charitable organizations that engaged in assisting the households. I then approached these organizations and government offices to recruit participants for semi-structured interviews about the social organization of care, social issues in the village, and their respective strategies for helping high-needs households. These interviews ranged from 30 minutes to one-and-a-half hours, but were on average around 50 minutes.

In total, with the aid of my interpreter, I interviewed 14 caregivers, 6 CHBC volunteers, 5 social workers (including the coordinator of CHBC), 10 government agents (including councilors and VDC members), and 10 NGO workers and administrators (ranging from supervisors to local coordinators and field officers). These were in addition to interviews collected during preliminary research in 2012 (12 caregiver and 12 volunteer interviews) on the topic of caregiving. During this preliminary period, I also began to conduct home-visits with volunteers and attend volunteer meetings. In 2017, I briefly returned to my field-site and followed up with existing participants, conducting eight further interview meetings with CHBC volunteers, community association members and a district councilor.

Throughout these periods of data collection, I also engaged in participant observation in the homes of a few key informants (both caregivers and volunteers), CHBC volunteer meetings, public clinics, my church fellowship, kgotla assemblies, and local community associations. I developed a rapport with the CHBC volunteers by attending their monthly general meetings, both during and prior to data collection. I rented a room in the compound of the Kgosa (sub-chief) of an older ward near the center of the village. This provided me opportunity to participate
in routine community events, including many weddings and funerals, *bogodi* (engagement) ceremonies, VDC elections, and gatherings at the *kgotla* next to the yard. The relationships that I developed with interlocutors also allowed me to travel around the village to observe various clinic health initiatives, NGO meetings, and *kgotla* events. My neighbors and local councilors invited me to observe and interact with community associations engaged in home-care support, sanitation, community health, income-generation, and assistance for those with disabilities. I also helped organize a workshop with the recently revived Village Health Committee (VHC) and participated in their training and orientation. I helped organize workshops for four different associations and committees and assisted with fund-raisers and by writing letters of support for their projects.

*Recruitment and Research Ethics*

In addition to approval by the Washington University IRB, my research project was approved by the IRB at the University of Botswana through the Research Ethics office. They recommended that I take certain precautions due to the social stigma that the chronically ill and their caregivers still face within the country. Although there were no known financial, legal, or physical risks to participating in this study, caregivers of the chronically ill represent a population with increased vulnerability and the study might have presented some psychological or social risks to this group.

To minimize these risks during data collection, I implemented measures to protect their privacy and maximize the comfort of participants. These included conducting the interviews privately with caregivers at a time and location they selected; in the case of family caregivers, all interviews were conducted in their home. The potential risks were stated during the consent procedure so that participants were made aware that they may choose not to respond to questions
or to terminate the interview at any time. The interviews did not include questions about sensitive topics such as the specific health conditions of the patients and all data was de-identified from the specific individual. I have preserved their privacy by using pseudonyms for all interlocutors throughout the dissertation.

Recruitment procedures were developed with the assistance of CHBC volunteers after the issuance of a government research permit. My interpreter and I informed the CHBC volunteers about the study goals and procedures and asked them to obtain permission from registered families for us to come and complete a survey in their home. We then contacted the volunteers and scheduled a time to for them to introduce us to families who had consented to meet us (see Fig. 2). Upon introduction, the volunteers left us with the caregivers for privacy and we read the participant the informed consent form, which they signed when they agreed to be interviewed.

Figure 2. Volunteers accompanied us to introduce us to participant households. Volunteers often travelled long distances on foot to reach their clients. Photo by author.
After the survey was completed we gave the informants the option to be contacted for a follow-up interview and for those who agreed, we obtained a phone number to contact them. All surveys were identified by a number code rather than personal information. For the sample of families recruited for follow-up interviews, we contacted them by phone to arrange the meeting and completed the informed consent process again for each interviewee. Among the low-risk research populations, including government agents and NGO workers, we contacted the participants by phone initially and allowed them to determine the time and location of the interview. This was occasionally in their office or workplace, but in several instances, these were also done in their homes. All interviewees signed an Informed Consent form prior to beginning the interview.

I elected to use non-monetary compensation for my participants per my IRB guidelines. For the surveys, I brought a gift basket of fresh vegetables for the participants that I provided at the completion of the questionnaire. These was purchased from a local farmer, and included a package of tomatoes, peppers, and onions, and a bundle of fresh spinach or greens. I opted to provide food as a gift because I was aware that seshabo (vegetables served alongside starches) were frequently missing in the diets of patients. For the follow-up interviews, which could be more time-consuming for participants, I brought a larger gift basket with food and small toiletries. This included vegetables, fruit juice, dried beans or ground meat, soup or gravy, and bread. I compensated volunteers for their interviews with similar food gift baskets. With government officers and NGO workers, I elected to compensate them with pens, office supplies, or mobile phone airtime. On consultation with my research assistant, we decided that the food basket gift might not be appropriate for a person of the status of politician or social worker. With
several of the NGO volunteers who I interviewed and got to know over time, I would buy food
or meals when we were together.

Local Ethics and Social Stigma

I observed during the process of recruitment and data collection that the consent
procedure was of less significance to families and volunteers than the informal code of ethics
that governed the privacy of the patients and their families. Volunteers were explicit that their
duties including keeping any health or illness information private and to abstain from engaging
in gossip about the families. I was held to this same standard, and on more than one occasion my
interpreter warned me that if we leaked this information, people would no longer speak to us.

Although it is no longer the case that the majority of CHBC patients are living with HIV,
the persistent stigma of that illness continued to affect our research. Early in the data collection,
my interpreter and I were warned by people ranging from neighbors to taxi drivers that we
should be extremely careful about being in such close contact with these households. The
sensitivity of information about those living with HIV, or those who passed away during the
epidemic, hit home to me during an interview with Mma Mogolo. Mma Mogolo was in her 80s
and she lived with and cared for her bed-ridden sister Mma Baruti, who was also elderly. At the
end of our interview, Mma Mogolo began to share some stories of her late children, and she
elaborated on their illnesses and passing. She had lost three adult children, one son and two
daughters. When my interpreter Lebo noticed that I was recording the audio, she sharply warned
me that I should shut it off because the information was very “personal,” though I was confused
by this I complied.

After we said our goodbyes to Mma Mogolo, I asked why the recording was a problem.
She told me Mma Mogolo’s story about her children should be “off the record” (literally not
recorded) because she had mentioned her late children’s given names. As I expounded on the abstract importance of these stories for the research, Lebo focused on the danger of “leaking” information about specific others and the fact that she would be left to deal with the consequences if that happened. People who knew her personally would hold her responsible for such breaches after I was gone. I rushed to assure her of the privacy measures in place for safeguarding my data, that no one else would listen to the recordings, and that all saved information was de-identified to protect Mma Mogolo’s privacy. She seemed somewhat reassured but far from convinced that it was a good idea to record that portion of the conversation.

The urgency and immediacy of Lebo’s concern and her response to the recording caught me off-guard at the time. I came to see it as a powerful example of the entanglement of privacy and stigma that still surrounds HIV. Though the names were incomplete (just first names), and although they had passed away years ago, the fact that we might be able to tell others that they died of HIV-related illness made it socially dangerous information. Stigma lingered in the background of several instances when I was confronted by the dangers of handling such information in my research. In multiple cases, we would survey or interview a family and they would not explicitly mention the virus, only for Lebo or a CHBC volunteer to “unofficially” mention that there was someone living with HIV in the home. Over time I came to recognize some of the signs of the virus as well, including emaciation and the appearance of being much older than their age. Given the sensitivity of the topic, I did not broach it directly but allowed my interlocutors to choose to disclose the information unprompted.

Currently, the government provides free antiretroviral therapy (ART) for citizens, which has saved many lives. It is not a magic bullet, however, and the social dynamics of HIV continue
to play out in troubling ways. The instances in which we met bed-ridden and emaciated individuals were often cases where people had discontinued their treatment and fallen ill from TB or other serious complications. Locally, people referred to this as “defaulting” their treatment (using the English term) and it was a central concern of the community associations with which I worked. They explained that this problem was two-fold; first, stigma was a problem because people tried to hide their treatment by delaying picking up their pills at the clinic, or interrupting treatment to hide it from a partner. Second, both nurses and local people told me this was dangerous behavior because if someone was on and off treatment too much, the ART stopped being effective and they would catch a highly contagious (and deadly) form of TB.

During my time in the field, two participants passed away from such complications. Additionally, a friend of mine Banthathi, a young mother in her mid-20s, also passed away from complications after stopping treatment during a period of depression and family conflict. It was a painful loss to myself and her other friends precisely because it seemed preventable. In fact, local community members (from a self-help association) tried to intervene and counsel her and her mother, but they were unsuccessful. Ultimately, she did not get the help or therapy that she required in time to save her life. There are complex and on-going dynamics around chronic illness and HIV, and the way that I collected data reflects the sensitive nature of this information; I only recorded the health condition of the patient when families explicitly shared with me and I have relatively little data on the topic of HIV specifically.

Research Assistance

During my data collection, I worked closely with an interpreter, Lebo Hendrickx, who was from Serowe and served as a consultant and collaborator. As she helped me to translate my surveys and interview schedules into Setswana, she also offered insights and suggestions about
how to phrase or broach topics in culturally appropriate ways. As a *lekgoa* (the Tswana term for white person, literally “English-speaker”) without local ties, it would have been difficult for me alone to gain entry to the domestic spaces of chronic illness and care. Although it was not the case that Lebo personally knew my participants, having a Motswana person from the village asking questions phrased in proper Tswana and with an understanding of certain customs and manners of address, Lebo could set participants at ease and build trust in a way that I could not have done on my own.

In many ways, working with Lebo and my secondary interpreter Thabang, a student at the university, enabled me to more easily navigate being a white North-American outsider. Both women were from the ward in the village where I lived, and my work with them evolved into friendships that allowed me an entry point to get to know many others in my area. As Jemima Pierre (2013) has noted, there are on-going legacies of colonialism and white supremacy that express themselves in African societies, and I noted the prestige of whiteness quickly after my arrival. A friend of mine referred to this as Batswana’s “racism against themselves” and the assumption that “white” culture was a model to emulate. The long duration of my time in the village made a significant difference in the novelty of my presence, and many of my neighbors used kinship terminology to make a place for me there. I was often with Lebo, and people commonly referred to me as her younger sister (or her daughter’s aunt), other times I was the child of my landlady who was a respected elder in the area. I am cognizant of the way my whiteness benefited my research; including the willingness of politicians and bureaucrats to work with me and the ways that associations solicited my participation in their projects and meetings.

**Data Analysis Methods**

I want to contextualize the stories of my participants and the ethics of care within the broader material context of household composition and survival in the village. To access this
bigger picture, I turned to my larger sample of survey responses. I coded and compiled the responses into an excel spreadsheet. I ran frequency and pivot tables in Excel to provide descriptive and comparative statistics from the data. Food insecurity scores were compiled following HFIAS protocol, which gave each household a number on a scale from 0 (no perceived food insecurity) to 24 (highest perceived food insecurity). This analysis forms an important basis from which to extrapolate and understand the problem of care in its material and relational nexus.

I transcribed and translated the recorded interviews with the aid of a research assistant to ensure accuracy. I used MaxQDA software to inductively code my interview transcripts and field notes. This allowed me to organize a large amount of qualitative data and group different narratives and quotes by their relevant themes. This analysis strategy also helped me to see how key themes clustered and diverged among specific participant groups. The approach lends itself to the framework of empirical and conflictual ethics because it allowed me to construct the concepts of care from repetition amongst interlocutors and to understand the significant differences between the perspectives of differently positioned speakers.

The concept of care that I outline in the next chapter emerged from the process of analysis and poring over the words of my interlocutors, so too did the “problem” of care emerge from their stories paired with my observations of the rhythms and routines of life in the village. I did not expect to discover framings of failed or problematic care as frequently as I did, and as I encountered them, they also made visible the ways in which these failures opened spaces to critique specific others.

In the following chapter, I turn to the task of defining care as my object of study and developing the empirical approach that is necessary to make sense of how caregivers grapple with care, its practices, and its limitations. Specifically, I attend in depth to the definitions of care
offered by family caregivers, and begin to establish the empirical ethics that generate their critiques within the daily and ordinary labors that sustain caregiving. In doing so, I also demonstrate why and how care becomes an “ethical” domain, and the notions of personhood, social recognition, and human dignity that underlie it.
Chapter 3: Giving Care, Practice, and Affect

Defining and Practicing “Care”

Within the recent surge of anthropological attention to care (cf. M. I. Ticktin 2011; Mol, Moser, and Pols 2015; Kleinman 2008; Livingston 2012; Sufrin 2017; Stevenson 2014), the concept of care itself has remained shifting and unstable (Buch 2015). It variously refers to everyday practices, biomedical projects, biopolitics, affective states, moral experience and obligation, and even forms of exploitation. In this chapter, I am concerned with defining care as my object of study, and I do so with an empirical approach using the narratives and routines of my interlocutors. This requires that I attend to the ways that caregivers explain and demonstrate how care is (and should be) practiced, and the inherently relational context of acts and dispositions of care. I also demonstrate why and how care becomes an “ethical” domain, and the notions of personhood, social recognition, and human dignity that underlie it. This approach reveals the social and relational contexts in which care is practiced and evaluated, which helps establish a framework for understanding interlocutors’ focus on the limits or absence of care in the next chapter. Though I focus in this chapter specifically on family caregivers’ definition of care, I will attend to the role of care in the practice of governance and relation between state and citizen in my discussion of bureaucratic care in Chapter 5.

Scholarly Engagements with Care

Scholars of care, from both anthropological and philosophical traditions, have focused on the importance of practice to the definition and study of care (Hamington 2004; Held 2005; Aulino 2016); that is, the physical tasks, activities, and routines associated with meeting the human needs of another person. In fact, intention or emotional investment is generally considered inadequate as a definition of care if it lacks the practical engaged face-to-face work of
The practices that constitute care are profoundly contextual, as they always exist within specifically situated relations.

Many scholars have argued that care is the foundational human practice that supports dependency, a universal feature across the life course (Kleinman 2009). Yet, as will become clear in the following chapters, daily care is also essential to how households navigate their interdependence and reciprocity of various resources such as money, food, and labor. For this reason, care work is integrated within the many routine and unremarkable daily tasks of social reproduction in the home, tasks that fall mainly to women (Leira 1994; Liebelt 2015).

My conversations with Batswana caregivers suggest that the tasks of care fall into several categories of interpersonal activity that maintain the appearance and dignity of a loved-one and their lelwapa (family or household). It is important to recognize that these practices are often oriented to provision, thus serving as a resource that sustains life itself. As I demonstrate however, meaningful care practices amongst interlocutors interwove physical and emotional labor, reflecting the importance of the relational body and its permeable nature. I will explore these enmeshed bodily and affective labors first by outlining the physical labors associated with care among my participants, followed by a review of the emotional and dispositional states that caregivers described as ideally underlying care practices.

Interlocutors repeatedly associated specific forms of labor with caring for a relative, including: bathing, feeding, dressing, washing, moving, and transporting a person. These activities revolved around an ideal of care that could produce a presentable appearance and demonstrate the dignity of the dependent person. Among family caregivers the practical tasks of caregiving were centrally concerned with a clean environment and proper shelter, preventing hunger, exposure, and managing waste and dirt so as the individual did not offend social
expectations. Interlocutors defined care by both the states it achieved and those it prevented, as when Mma Ntebela described how she cared for her husband, “I don’t want him to be dirty so I bathe him, also we feed him in the evening so that he doesn’t sleep hungry.”

Family caregivers described caregiving routines as tasks integrated into a daily flow of activity within the household. For instance, Mma Kubu, a woman in her mid-60s, described her routine care for her ailing elder brother, “I take him to the hospital when the disease gets worse. Here at home I am the one who cooks for him, who bathes him and does his washing.” Mma Orogile, who cared for her elderly mother-in-law in her home, described a similar suite of tasks, “My most important responsibilities are to see that my patient eats, is bathed, and that her house and yard are a clean environment.” These descriptions are representative of the most common themes among my participants: feeding the patient and ensuring that their bodies and home environment are clean.

Based on my interactions with my interlocutors, I have identified nine practices, which fall into four principle categories, each of which also have associated ethical values: 1) cleanliness / dignity, 2) handling the body / love, 3) medical treatment / physical well-being, and 4) visiting / social relatedness. I will examine each category in turn to unpack the definitions, activities, and settings in which these elements of care become important.

**Cleanliness and Dignity**

**Bathing and Personal Cleanliness**

*Karabelo lost the use of her legs seven years ago; since then, she has lived with her mother and four young children in her mother’s yard. She requires a wheelchair now and has difficulty navigating the rocky unpaved roads. She has not been able to maintain a job since her paralysis. Karabelo now relies heavily on her mother for help with daily tasks. Every morning, the women place a plastic sheet over Karabelo’s bed, she then lifts herself onto the sheet with
her mother’s help. After filling a bucket with warm water and soap, Karabelo’s mother helps her to wipe herself clean, reaching the spots that she cannot. Karabelo’s children are still in primary school, so it falls to her mother to bathe her every day. This form of “bed-bathing” was common among participants due to the mobility issues of the elderly and those with disability.

I begin my examination of caregiving practice with the work of bathing the patient and keeping their body clean. The unruliness of bodily fluids and physical debilities are closely managed in Botswana as a measure of sociability and personhood. As Livingston (2008) has shown, the sentiment of respect towards others based on common humanity (botho) is interrupted by disgust at the appearance of fluids like saliva, urine, or feces out of place, and caregivers work hard to preserve an appropriate or non-offensive appearance in their dependent.

The responsibility for bathing the patient did not fall evenly across household members, however, as bodily intimacy dictated certain prescriptions about who carried out this labor. Ideally, it fell to the closest same-sex relations (i.e. a daughter or sister), or to spouses if one was married. Younger relations, like grandchildren, were not often asked to step up in this intimate way. For instance, Mma Ngake had a few adolescent children living in the house with her, but she bore the primary responsibility for bathing her mother. She told me, “When I leave her with them they will phone me and say she’s refusing to bathe and she’s too heavy and then I’ll have to come back and bathe her.” Mma Ngake’s case highlights the habitual nature of such practice, and the ways that routine repetition makes one more capable with the intimate labor (Aulino 2016). She had become the primary bather because of her strength, her familiarity with the process, and her mother’s comfort at being bathed by her daughter.

As in Mma Ngake’s case, the role of keeping a patient clean commonly falls to daughters or wives; only in the cases where this is not possible do other relatives step in to engage in such
body work. For instance, Kalafo was a young woman who stayed at home with her elderly uncle, but her caregiving tasks were shaped by her age and the distance of the relation. Her daily tasks were primarily to feed him his soft porridge and medication in the morning and to keep the house clean. She informed me that her mother and aunt did the more intimate care work: “They bathe him in the evening and then afterward they feed him again and give him the medication after he has eaten. The older ones [his sisters] are the ones who bathe him.” Kalafo explained it would have been preferable for his brothers to bathe him, as she said, “He has brothers, but they don’t have the decency to help care for him, because they are just staying where they are.” When we asked her what sort of help she would like to see from her relatives, she returned to the topic of his brothers, “They are supposed to help bathe the patient at least, because he is a man and my mother a woman.” There were boundaries of appropriate intimacy between men and women that played an important role in who could engage in such close contact, ideally it should be spouses.

We spoke to Mma Ntebela about her struggles to give this intimate care to her husband, she explained, “The wife is the one who should be able to do everything, but with me, at times I am weak. A wife should bathe him, dress him, but I’m not very keen or strong.” Due to her own poor health and strength she would often ask her son Moabi at home to help with these tasks, “We don’t want him to be dirty so we bathe him. We dress him with clean clothes.”

The need for routine bathing increased when patients were incontinent or dealing with illnesses that caused diarrhea. Such conditions required not only extra labor on washing but extra resources to manage the waste properly. Caregivers often referenced this indirectly, as when Mma Ngake informed me that she only occasionally used the clinic-supplied gloves when bathing her mother, “I only bathe her with gloves when she is ‘not feeling well’, you understand what I mean?” She sometimes struggled against her mother’s refusal to bathe, telling me about
the pain this would cause her, “That’s when I get hurt, when she refuses to bathe. I will tell her if
she doesn’t bathe other people will say that I don’t take care of her.” Mma Dibela was more
direct in mentioning the task of cleaning her son’s waste, “He can’t do anything for himself, he
will even poo in the blankets.” For a person to smell or be covered in their own waste was
powerfully anti-social and thus a clear social indicator to others that the individual did not have
relatives who properly managed their duties (see also Dahl 2014).

Managing the waste and cleanliness of an incontinent person required substantial
resources. Families registered in home-based care could request a pack of adult diapers from the
clinic, yet for many this still proved insufficient. Mma Okamela explained the challenge, “They
only give us one packet [10 diapers]. So even when she [her mother] has diarrhea and we will go
back to them they will refuse, and say you already got your supply yesterday.” Even when Mma
Okamela had not claimed her package for the month she faced setbacks, “I went to the clinic to
ask for diapers, and they told me they were out and that I had to come back at 3pm. So I went
back home to cook for her and then went back again at 3. When I came home again, I found that
she has had diarrhea on the bedding and I have to wash it.” She also noted that the gloves
supplied by the clinic were too small and flimsy for the task of washing soiled clothes or
bedding, “I tell them the ones they give me are small and get wet when I wear them, even the
diarrhea gets into the gloves while you are scrubbing.” Mma Rona, caring for a daughter with
disability, described the Home-based Care program in terms of such materials, “Hm, the program
they only help me with... the nappies. It is tough, if there are no nappies at the clinic, I struggle to
know where to find them and find help.” She noted that the clinic was usually able to provide her
with plastic “hazardous waste” bags and gloves to dispose of the diapers properly.
Cleaning materials and products, including soap and disinfectant, were other major costs for this routine labor. During my fieldwork in 2015, however, the clinics had stopped providing the cleaners and bleach to families. Mma Puso, who cared for a younger brother with HIV through many ups and downs in his health, told me, “We get gloves, at times if he has diarrhea I will get pampers. Most of the materials, like Dettol [disinfectant] are not at the clinic or hospital, so when we have the money we have to buy it.” At the time of our first visit, her brother Jonas could sit up and chat with us, a few months later his health had left him bedridden and incontinent. She said, “Now the Dettol finishes fast because of his situation. Before when he used to be better we never used it. We use the gloves more often too.”

Other caregivers told a similar story, Mma Gorosa explained that the need for these materials motivated her to ask a doctor about the home-based care program, “My husband couldn't walk, he couldn't go to the toilet. I needed gloves, and I joined home-based care because there were no gloves at home and no masks to wear to help him.” Though the intent was good, some of the home-based care volunteers noted that the clinic did not provide all the necessities any more. Mma Mpopi a volunteer since 2000, remarked, “With washing powder, you’ll find that at the hospital they give them nappies and from there the patient won’t have washing powder for their clothes to be washed.”

The labor of bathing and attending to dirt on the surface of the body is an interpersonal and intimate practice deeply connected to the producing human dignity and facilitating social integration through the aversion of disgust in others (Livingston 2008). Cleansing the surface of the body is a matter of “civic morality” in Botswana (Klaits 2010, 132). Failing to bathe a loved one simultaneously signifies the absence of love in a household and offends expectations of public manners (maitseo) (Durham 2005). The surface of the body becomes morally-charged as
it mediates the self and the social. In Botswana, as many other parts of the world, the physical appearance and state of the bodily surface signifies inclusion in (or separation from) the community (Masquelier 2005, 5). Kalafo’s statement about her male cousins lacking the “decency” to help bathe their uncle demonstrates how the labor of caregivers in this domain constitutes them as a moral agent. Moral agency in caregiving encompasses dual meanings; both the restraint of inhumane behaviors and the power to act humanely (with “decency”) toward others by attending to their body (Bandura 2002).

**Washing Clothes and Bedding**

This category of caring labor includes the provision of clean attire, since undress, and dirty or smelly clothes, also contravened the dignity of a person and their exclusion from public life (Masquelier 2005). Much like dirt on the body, dirty or ragged clothes signified that a person had no one taking proper care of them. Mma Ntebela reiterated the link between bathing the patient and keeping them in proper attire, “To take care of him, we bathe him, do his washing, and feed him. We dress him with clean clothes.” The ability to wash the clothes of residents was an essential part of routine labor in any household, but among caregivers for the chronically ill there was special emphasis on the importance of the overall cleanliness of their body and environment. This was often physically demanding work, none of the households in my sample owned a washing machine so clothes and even heavy bedding were washed by hand outside in the yard.

Mma Bana had two children with disabilities who she cared for at home; she described the importance of washing their clothes are part of keeping her children in “good condition.” she explained, “You have to see if they are in good condition, if they have eaten well, and to see that where they sleep is clean and tidy, and their clothes are clean and washed well.” Mma Ngake
described the challenge she faced in keeping her mother and her clothes clean and presentable to others, “Sometimes after I have bathed her she will say she’s feeling cold, she wants the sun. She normally crawls and dirties her dresses, when I tell her it’s not right what she’s doing she will feel it’s a challenge and then she’ll get angry and annoyed.”

This is a type of care work that younger relations may help with at home, even those who are not intimate enough with the patient to touch their body or bathe them. For instance, Sara who assisted her grandmother caring for her grandfather, described her main tasks as “I only help to feed him soft porridge and to make sure the clothes are washed.” Across the village, Dimpho would regularly visit her mother Mma Ntebela to assist with tasks like washing, although she did not live at home with her parents any longer. She complained about her ailing father’s clothes because he was not in proper attire to have visitors like us. She said, “If it was up to me, you wouldn’t be finding him with a torn jacket like now when you’ve just arrived. When a person grows old, he has his own bad smell, if only he had lotion and new clothes it could be better.”

In describing the task of keeping the clothes and bedding clean, many caregivers also spoke about the chronic lack of resources that impeded this. Sara, who helped care for her grandfather, told me, “It is very important that we have to have materials to use for care. That way the patient can be presentable, he has to be clean.” In her household, such materials were often in short supply. Others spoke about the chronic anxiety that these missing resources caused because it interrupted this duty. Mma Okamela, who lived with her elderly bed-ridden mother, explained to me, “When the month ends we normally have no soap for bathing. Most of the time I will be looking for washing powder which I need a lot for bedding, I am the only one washing… When there is no soap, I will run around and ask [neighbors] for some to wash her
clothes.” The need to keep the bodies and clothing of the sick in proper condition thus generated significant pressure on low income households.

The importance of appearance and attire were social expectations that I also learned about as I found myself caught up in these forms of evaluation. My landlady started to routinely admonish me for the appearance of the hooded jacket that I often wore, which had become dusty and dirty on the arms and cuffs. Her persistence led me to scrub my clothes a little harder the next time I did laundry. Even my shoulder bag, a simple canvas purse I carried with me everywhere, became dirty enough that my friend offered to wash it for me, since I did not seem interested in doing so myself. I did not end up washing it (after all, I used it every day to carry everything!) but I did in time come to be embarrassed by its dirtiness. The importance of appearance in the village communicated respect for oneself and others; it signals that one is a social agent and part of social life in a meaningful way. There is also linguistic evidence that dirt is morally ‘wrong;’ the term leswe indicates something dirty, while a closely related form of the word, maswe, means bad or ugly.

The importance of cleanliness related to sociability and appearance, and connected to health and well-being directly through one’s living conditions. Caregivers often phrased this in terms of the conditions where people slept. Mma Naledi, who cared for her live-in elderly mother, made this link explicit, “We see that where she sleeps is clean, and she sleeps on clean blankets that are not dirty. We have to make sure where she sleeps is always very clean.” Mma Puso cared for her younger brother who had gone blind as a complication of his condition. She also emphasized cleanliness of his sleeping area among her caregiving duties, “The responsibilities to care for the patient is to make sure where he sleeps is clean, his clothes are washed, that he eats well and that his bedroom is very clean.” Her brother Jonas, bed-ridden
during our later home visits, spent all his time in his room. Mma Puso reiterated that his bedding needed to be clean to prevent bed-sores.

Sara was also very worried about the state of her grandfather’s room, because his sleeping area was over-crowded and dirty. She told me, “The only thing I can talk about is the old man’s shelter, the way he is sleeping is not comfortable for him, I am a poor person so I cannot help.” She explained, “The windows are shattered but we don’t have money to fix them. When it rains, the house gets wet inside.” Moreover, the old man had to share this cramped space with many children and grandchildren. Sara worried a great deal about her father’s sleeping conditions, and repeatedly emphasized the importance of a clean environment, “The old man has to be where it’s very clean so that he can get better, you see it’s not very healthy to be sleeping where you also keep food.”

**Clean Environment**

My time spent with Home-based care volunteers revealed that they felt the work of cleaning was very important for the families they visited. Many of the volunteers had been part of the Village Housing Committee (VHC) in the 1990s before they joined home-based care. The VHC uses local volunteers to educate their neighbors about health and sanitation procedures like a clean yard and proper waste disposal. As Mma Bereki put it, the “VHC was to tell people around the yards to clean and take care of their environment.” This emphasis continued through her work with HBC, Mma Bereki continued, “First thing when I get there I will see if the patient is bathed, the house is swept and the bed is made.” Mma Mpopi, another volunteer, was even more explicit, “The first thing I look at is the environment, also if there is a pit latrine, those are the most important things to look for.” The volunteers were impressed with the improvement they had witnessed among families over the course of their time in the program. Mma Mpopi
explained, “When you enter the yard with a patient you’ll find that the house is clean, everything is done in a proper manner, and very clean, she will be looking very well.”

Mma Bereki agreed with this sentiment and the general improvement of patients’ conditions, “Nowadays there is not a lot of dirt (*leswe*), there are not lice and those ugly wounds that they used to have. You couldn’t even look at those wounds and eat afterward. Those things are no longer there when we visit.” Mma Molawa, who had volunteered since 1998, connected this general improvement to cleanliness, “There is a difference these days, especially when we visit patients at home it’s not as dirty (*mo go maswe*). The patients are improving very well now.” It is noteworthy that Mma Molawa used the term *maswe* to mean dirt in this context, because this form of the word is also commonly used to something bad or ugly. She offers a specific example of the close relationship of these concepts that blur the lines between a physical state (clean/dirty) and a moral state (good/bad). She also succinctly summarizes the assumption that the state of being clean leads to physical improvement in the health and body of the patient. In the next section, I examine how forms of touch and intimate contact are similarly morally loaded due to their association with love and linked to the physical well-being and healing of the body.

**Handling the Body and Love**

**Touch and Massage**

*When Mma Rona returns home in the evening from her job, she greets her three children. Her adolescent son and daughter help her care for her youngest girl, Tsolo. Tsolo, age 14, has a form of palsy that leaves her unable to speak or walk independently. Every day, either before or after work, Mma Rona makes time to massage her daughter’s limbs. She spreads Vaseline over her daughter’s arm and gently rubs in circles, eventually rubbing both arms and legs. She explains to me that this must be done regularly to prevent cramping and maintain blood flow.*
Although many caregivers specifically mentioned using gloves provided by the clinic, I was surprised to learn from the Home-based care volunteers that family members had initially resisted the introduction of gloves. As both Klaits (2010) and Livingston (2008) have noted, in Botswana touching a person during care was an expression of love, and gloves might be read as the refusal of skin contact as an indication of disgust or denial of love. The volunteers educated families on the use of gloves as a safety measure for their own health, given the close contact they were in with patients living with HIV. Mma Morula explained the importance of instilling this new understanding, “At times it is a patient who needs to be held with gloves. The patient’s children should be taught how to hold the patient properly rather than holding them without gloves. It’s not that holding them like that [with gloves] they don’t love them. We normally emphasize that they must use gloves.”

During my research, most caregivers accepted the need to use gloves, specifically if they were dealing with blood or fecal matter. It remained a difficult area for some caregivers, like Mma Ngake, who explained to me that, “I use the gloves most of the time. Normally when I bathe her [mother], when I put the gloves she doesn’t like it. She feels that I am disgusted to touch her. Even if I try to tell her the importance of putting gloves, she doesn’t take it well.” For family caregivers, touch was not limited to bathing the patient, in many case it related to other tasks like dressing wounds or doing massage (tsidilo) for the rehabilitation of patients with poor mobility. Mma Gorosa, caring for her husband after a stroke left him physically impaired, proudly told me, “Now that he is okay, he can go to the toilet alone, because I have been massaging him. I took responsibility from the physiotherapist so I stand up to do the massage. Even if I take him to the hospital or not, I take responsibility for massaging until he could walk,
even if he is not going far.” She received training through home-based care and attributed the healing touch as a key factor in him recovering some mobility.

Mma Puso also mentioned the importance of learning from experience when caregiving, which speaks to the embodied knowledge at the heart of caring labor (Hamington 2004; Aulino 2016). She told me, “I also took care of my husband. I have experience with how to take care of a patient like this one and what to do. I know a patient is supposed to be bathed, when he has wounds how to take care of them, I will know how to apply the body oil so that his skin doesn’t get dry.” She told me it was important to be very gentle with one’s touch, because the patient may not be strong. Mma Gontle mentioned touch as part of the process of soothing her mother when she was in distress or pain. She described the process, “That is also how I motivate her, with love, by also massaging her with my hands. I will also pray with her and I am able to ease down the pains in their body. At times, you’ll find that their feelings are very neglected so I will ease them.”

Touch, then, was a crucial aspect of caring practice. The intimacy of skin-to-skin contact, and the ability of massage to ease pain and emotional distress, was tied up with the understanding that loving touch has a healing power (Livingston 2005). It was an intimate domain in which not all relatives felt comfortable, much like bathing. Karabelo, confined to a wheelchair since 2010, recounted to me that people expressed true loving care when they massaged and stretched her legs to ease her pain. Although she had asked for this help from her sisters, only her mother and her own children felt close enough to her to routinely help with this therapeutic touch.

**Lifting and Moving**
Caregiving among family members was a hands-on affair. Many caregivers expressed the difficulties they faced in physically moving the patient. Only in a few cases did the person have a working wheelchair to facilitate this process. Even for someone in a wheelchair like Karabelo, she felt that her relatives should express their care by offering to take her out to the mall and help her get around. She used this as an ideal example, while pointing out that this did not actually happen – instead she stayed home except when she had money for a taxi to the mall or when her adolescent son pushed her wheelchair to the local clinic for her check-ups.

Mma Dibela, whose disabled son Thapelo did not have a wheelchair, elaborated that the more difficult work of care related to moving her son, “We lift him, knowing that a child like him cannot do anything for himself. It is difficult. In the morning, we lift him up to take him outside, then in the evening we lift him up to put him back in the house.” This was difficult physical work, as Thabelo was 16 years old and was not small for his age. Later Mma Dibela mentioned that the challenge of moving him extended to seeking services that took them outside of the household. She explained, “I haven’t even taken the Omang [Government ID card] for him because he doesn’t have a wheelchair, there is nothing to take him. I don’t have a problem to book a taxi but the problem is he is too heavy to be lifted, like for instance last time I went to Francistown it was very difficult for me to lift him up with my hands when lining up.”

The difficulty of moving a bed-ridden patient increased when the primary caregiver at home was also elderly. Mma Okamela, who was 65 years old, felt the strain of this most often when she bathed her mother. As she explains, “I’ve stayed with my mother for a long time I have never had anyone come here to help me bathe my mother. I bathe her by sitting her down on a chair with a plastic sheet over the seat.” Mma Okamela could occasionally get the help of a younger person, or as she put it, “When my grandchild is around – when she hasn’t gone to work
– I will call her to come and help me. When she is not there, in the morning, I will just struggle on my own and put her on the floor instead of the chair. If you see now by the water there, I bathe her by putting a plastic on the mattress on the floor.” Mma Kubu, at 62 years old and already frail, imagined how much easier the physical tasks of lifting and moving might be if she had more family support, “If I had relatives, my child, for instance my older sisters or brothers – if I had them, I would ask them to help me to bathe him together and to take him to the clinic when I am not there.”

**Food Provision**

Securing food for the patient is a central aspect of sustaining the body; it caused many caregivers emotional distress that they struggled to feed their patients. Caregivers placed utmost importance on feeding their patients, both to prevent hunger and in the cases when they needed to take medication. Cooking was often the responsibility of younger female kin, while older caregivers might focus on other intimate bodily aspects of care. For instance, Mma Mogolo, a woman in her eighties had moved into the yard of her elderly sister when the sister became bedridden. Given her advanced age, Mma Mogolo described the division of caring labor with her sister’s daughter, “We feed her – but those who cook are the children. I only bathe her and do the washing for her.” Similarly, Mpho described helping her grandmother with her grandfather’s care, “As children, we just help to make sure he has enough food to eat.”

Many caregivers echoed the importance of adequate food for the patient. Mma Naledi cared for an elderly mother and explained, “You have to make sure that your parent has eaten well and to see that she is well. You have to see that whatever she eats is in the house. We make sure if something is short, to see what we can do so that our mother will be able to survive.” Households often had to carefully manage and budget a limited amount of food due to the
financial limitations. Mma Dibela, who was working and brought in a steady income, still had to carefully monitor food provision and strategize around how to stretch her paycheck throughout the whole month. She explained to me, “We normally buy food once at month’s end. When I am not around they will cook and save some so that when he is hungry someone will be able to dish food for him.” In several households, the caregivers explained that even with careful budgeting it was a struggle to make food last the whole month. Once the food had run out, they would have to appeal to other household members to contribute something small to tide over the household. Kalafo explained that once the monthly provisions were out, “We will ask others to buy for us. Even when the food finishes we must see that he does not sleep without eating anything.”

Boikanyo and his sister Sarona, recounted to me how they struggled to get enough food for their aunt’s ART. Boikanyo told me, “With food we just struggle, it was much better when she was still getting the money for food and seshabo [meat].” He is referring to the food subsidy that his aunt was given when initially registered in Home-based care. This took the form of a paper “voucher” worth 650 pula per month, with an additional 150 pula specifically to pay for the cost of meat (seshabo). The voucher is designed as a temporary measure, and when her condition stabilized on ART, the social worker did not renew the voucher. The entire household acutely felt the loss of that supplementary income. A young mother named Bontle explained to me the challenge of eating well while you are sick and without adequate income. She told me, “If you are not working life is very difficult. You have to look after your child and if you are not well, you are supposed to make sure that you have a balanced diet so it is very difficult.”

In the above cases and in many other families I met, the uncertainty around securing adequate food provision was a chronic form of stress caregivers must manage. This anxiety was tied into the cycle of paychecks, pension money, or food subsidy payments, all which were
transferred to people during the first day of every month. Mma Okamela told me that she dealt with this concern monthly, “When the month is about to end there is nothing we can cook for her. I am struggling with the old woman I don’t know what to do. At times, I don’t know what to feed her.” These frustrations speak to the importance of cooking and feeding as a routine caring practice, one which bridges between loving care of a body and the medical regime of pharmaceutical treatment. It is also noteworthy that feeding, much like we will see with transportation, is a central domain in which caregivers became aware of the limitations of care and resources from their social networks.

**Medical Treatment and Well-Being**

**Transportation**

*Mma Dibela had an appointment for her son Thapelo at Nyangabwe Hospital in Francistown, which was a 4-hour drive from Serowe. It was the closest hospital with specialists who could help with his condition. She had no car of her own, and she dreaded having to take him on the bus. The last time she brought Thapelo to the hospital on the public bus was a struggle for her because he did not have a working wheelchair. He was too heavily for her to lift or carry easily, and she’d had to ask for help from the conductor to carry him up the stairs to the raised seating and to off-load him as well. Once they arrived in Francistown, Thapelo had to sit on the ground while she hired a taxi to the hospital, again asking for assistance from the driver to lift and move him. This time she had requested an “ambulance” from Serowe Hospital. She told me that she was trying to book this option because it was free (due to his condition) but all of Serowe was served by only one ambulance and they had not returned her call to confirm the transportation.*

Transporting a bed-ridden patient was stressful, especially if it involved long distances to secure treatment or attend check-ups. If it only involved collecting medications, then caregivers
could sometimes travel alone to collect it on behalf of their patient. To seek either emergency care or make it to routine check-ups was much more complex for caregivers, given the difficulties imposed by poverty to pay for transit. Only 18% percent of surveyed households owned a working vehicle that they kept at their residence. The majority, then, were dependent on public transportation.

The public transit in the village takes the form of a dozen combi (passenger van) routes, which depart and arrive at the main “bus rank” in the center of town. The only option that will pick you up directly from your home, however, is hiring a “taxi special.” A taxi special costs a minimum of 20 pula for a one-way trip, and even more if you’re travelling to or from the outskirts of the village. Caregivers of people with impaired mobility often spoke of having to hire the special taxi to get around the village, given the challenge of using combi buses, which are packed with people and require the ability to physically navigate tight spaces. Mma Bana, who lived with two adult children with disabilities, explained to me, “We call a special taxi to come pick us up because public transport is normally very difficult for them [the children]. For instance, when we needed to go collect the boy’s Omang (ID) from Immigration, we had to book a taxi.” Such a round trip would cost them a minimum of 40 Pula, which placed it outside of the range of many caregivers on a limited income. The financial burden of transport, necessary for the proper care of the patient, was a common point of struggle among my participants.

For instance, Mma Dikeledi explained, “If there isn’t any car to borrow or hire – it is a problem to pick up her medication.” Another interlocutor, Mma Keabetswe, who was also caring for a bed-ridden elderly mother, echoed this challenge, “It is not easy because she cannot walk, it is fortunate that she is not sick right now. She cannot even get in a car, right now she has a sore but we are treating it at home. They encouraged her to go for an HIV test, but she could not
because there was no transport so they came to test her at home. But it is not possible for the hospital workers to come see her at home.” Mma Lerato described the anxiety she felt throughout this process, “When my mother becomes very sick, I get scared, more so because it is a problem to take her to the hospital. I hire a car if I can but sometimes it’s too many appointments, even 2 or 3 times a week.” It was not uncommon for caregivers to speak about being unable to transport the patient when necessary.

Mma Keletso, at the time of our first meeting in 2012, was feeling very frustrated about the daily hardships of caring for her daughter Keeya who was on ART. One of the first frustrations she voiced was how their lack of money made it impossible to keep up with treatment. Mma Keletso explained, “Last time I was supposed to take her to the hospital, I couldn't because there was no money. I am having a problem with this child because they have changed her medication. She is not well.” A shortage of money was a key feature of caregiver headaches as they attempted to oversee the health of their patients. Lesego, a middle-aged woman who assisted her mother with caring for her uncle (mother’s brother), explained the financial burden this posed, “We'll have to pay the transport that will take him to the hospital so it needs a lot of money. Sometimes if there is no money we miss check-ups. Everywhere we go we have to take a taxi, so that is the main challenge”

Boikanyo and his sister Sarona, both of whom were unemployed, described the stress of getting their aunt to the hospital when the single “free” ambulance was not available, “If she is very sick we are the ones to call an ambulance from the hospital, if it’s not there then we have to run around to get money so that we’re able to hire a taxi to take her.” Boikanyo went onto describe that their only alternative was to incur debt to their neighbors to pay for transportation, “When we don’t have any money, we will borrow it from others so that we can take her to the
clinic. If we do not do that, there is no way we will take her. When they loan us the money, they
tell us to pay back with an interest.” Although health care for citizens in Botswana is very low
cost, transportation remains one the principle mechanisms that imposes a financial burden on
families that may deepen or entrench poverty.

Transportation was a central area, due to its demand for financial resources, in which
caregivers experienced the ‘absence’ of care from their relations. Mma Tebele gave me an
example of this dilemma, “We do not have transport to take her to the hospital. We don’t have
money to pay transportation. There is no one to help with that cost. My children sometimes come
to visit Serowe, only on those days they can help.” Mma Gaone, who’s adolescent son had both
physical and cognitive impairments, described this dilemma, “Since 2010, he is not getting
better. The other siblings are working far from here so I have a problem with transportation.
Sometimes I use a wheelbarrow to take him to the clinic.” Having to transport a person in a
wheelbarrow was frowned upon, an undignified and de-humanizing process, and yet for some
caregivers it was their only option despite the shame it might bring.

**Managing Medication Regimes**

Transporting patients to the clinic or hospital was a crucial responsibility for caregivers
because medical treatment was key to sustaining their lives and health. The home-based care
volunteers emphasized the importance of this repeatedly. Mma Morula told me that she
encouraged her patients at home to get to their medical appointments. She explained, “The
clinics really care for them well. We try to motivate people to go to the clinics to see the doctor
and at times they are referred to the hospital so that they can get proper care.” She motivated her
own relatives to seek treatment, especially given the reality of HIV and TB in the country. She
recounted,
Even in my family I motivate them, especially my children and younger siblings, that they should go for testing. The HIV virus is nothing to fear, it’s a disease like any other and they ended up going for testing. One of my children had HIV and then I told her she should take precautions and go to the clinic to get the TB injection. She is now on TB prevention treatment and now I motivate her to take them well because if she doesn’t take her treatment properly it will be only me, there will be no one to help her when she is sick.

Though the volunteers might provide the motivation, it was the family caregivers who were tasked with managing pharmaceutical treatment for their loved one. Mma Naledi emphasized the importance of her mother’s medication routine, “We make sure that she is doing well. First, we make food for her, from there we give her medication. We make sure that she doesn’t get hungry. In the evening, we’ll see if she has eaten well and then give her the medication and see she takes it properly.” Boikanyo similarly emphasized that his role as caregiver included making sure his auntie could regularly take her ART tablets. He explained, “We cook for her, I fetch wood, we both buy food together so that she can take her medication properly.” Mma often felt sick on her previous ART regime after taking the tablets and she explained, “I have to eat something before I take them or I am going to shake.”

Those living with HIV can access combined HAART through the clinics. When we met, Bontle was a young mother who had just started in home-based care when she and her son were enrolled onto ART at the local clinic. She described the importance of managing treatment for them both, “I realized that the patient is myself and a child, I have to make sure that every time we have to take the right treatment at the right time and make sure that we have had a meal – we are not supposed to take the treatment hungry.” Kalafo, who stayed with her uncle while her mother and aunt went to work explained that he initially had moved into their yard when he was no longer able to manage his own treatment. This had forced them to move him into the village from where he stayed at the cattle post. She told me, “When he was there he was not taking his
medication properly and he became sick, but when he is here he’s fine.” She attributed his improvement with the careful routine of care that his sisters had established, “They [his sisters] bath him in the evening and then afterward they cook and feed him, then they will give him the medication after he has eaten.” She demonstrates how the medicalized elements of care, in this case, administering drugs or treatment blends into the routines of cooking and basic social reproduction within the household.

It was also clear to caregivers, however, that the medication kept their loved-one from rapidly physically deteriorating. This is a legacy of the HIV epidemic before the roll-out of ART, when patients would waste away, going through a stark physical transformation and breakdown. Many people also explained to me that if a person disrupted ART, they might catch aggressive and contagious TB that would not respond to treatment. Mma Bereki concisely sums up the relationship between medication and sustaining life. She explained, “I will tell them [patients] that if they take their medications well from the clinic they will live longer and keep their life. If they don’t do what they need to do, they are playing with their life – that is when they start to have problems and might lose their life.”

**Visiting and Social Relations**

This caring practice represents constitutes a category on its own. I attend to this practice as the last of the physical tasks identified by caregivers because it forms a bridge between the physical labors of care, in terms of physically presence, and the associated emotional labors that caregivers identified. My interlocutors often referred to visiting (or lack thereof) to assess which relatives were there for them. Visiting could sometime imply that the visitor would assist with physical labor of care, but also could refer to simply checking in to provide social and moral support and companionship. When I asked Mma Okamela who among her family assisted her with her mother, she explained “my auntie who stays in Rakgomo ward, she sometimes comes
but only every few months. When she comes, she helps me so that I can relax my body.” This was a very important distinction from her other relatives; she recounted “the role for them is to come and visit and help and see what to feed the patient, and to assist in lifting her.” Mma Naledi, who cared for her mother without much help from her siblings, also expressed a similar desire. She said, “A person who helps you is a person who visits at times. I can say that it can help me up because they can come and assist to care for her.”

Kalafo, caring for her ailing uncle, indicated the relationship between visiting and the performance and affirmation of relatedness. A neighbor of her mother’s family had become like kin to them; as such, she was a frequent visitor to the old man. Kalafo told me, “There is a neighbor from my mother’s side. She normally comes to visit the patient.” Visiting is a powerfully sociable act in Tswana society. Klaits (2010) proposes that visiting is among a suite of “housing activities” that occur within a domestic space as part of the process of building the home and the relations that sustain it (31). Visiting involves people in one another’s welfare and has an impact on the well-being of people’s bodies by generating sentiments of love and care. When visiting it is important to speak kindly and engage in prayer or song to demonstrate one’s love, thus refusal to visit may be read as very anti-social or even suspicious (ibid).

Multiple caregivers associated receiving visits with the improvement of their emotional well-being. Bontle, who had only recently joined Home-based care, described the impact of regular visits from the volunteers, she told me, “I have learned that there are some people who are very caring. If you are very sick, they come visit you. So that motivates you. They show a lot of caring and love every time they visit you.” Caregivers also knew that the volunteers who visited could inform the staff at the clinic if they fell sick.
Caregivers also appreciated visits from neighbors. For instance, Mma Lerato told me that these made her feel less isolated. As she put it, “They [neighbors] sometimes come around and ask me how the old lady is doing. That is when I can see that I am not alone.” She went on to describe the visits of the home-based care volunteers, “They help by seeing how she is doing. Afterward, we pray and then that is it.” Mma Lerato expressed the difference this made, “I can see people coming to see how my mother is. I am very grateful they are trying.” This effort on the part of volunteers was noted as a key feature of changing social practices around illness by the caregivers themselves. For instance, Sara described the impact of home-based care, “It’s not like before because we used to take care of patients alone at home. Now they visit to see if the patient is getting better and how they can assist. It has really changed now that they are visiting people at home.” Visiting has become a crucial part of the work of the HBC volunteers.

According to several caregivers, however, the visits from the volunteers did not contribute to care when they did not pitch in with physical tasks or material needs. For example, Mma Tsweu cared for her blind husband though she herself was not in good health. She told me, “The one who comes to visit the old man is the volunteer, even though she is not well… Normally when she comes she just comes to check him and she doesn’t help with anything.” Mma Okamela was more pointed in her critique, as she felt that volunteers ignored her struggle even when it was right in front of them. As she put it, “When they come here and find that you are struggling to wash the old lady they will not assist you. Or they won’t even carry the old lady with them to help us.” Much like volunteers, whether or not kin visit (and what they do while visiting) provides a crucial lens through which caregivers judge their relatives to be helping or neglecting them.
Caring as Emotional Labor

This section of the chapter describes the emotional dispositions that caregivers describe to be crucial to their patient’s well-being. This reflects existing ethnographic analysis of the permeability of affective and bodily states in Tswana social life (Klaits 2010; Livingston 2008). At its core, caregiving is a relational process (Held 2005). The attitudes and behaviors of the recipient of care shape the forms of caring emotion and practice that are necessary on the part of the caregiver. I have identified five primary affective practices according to interlocutors, which are grouped into two categories. The first category entails managing one’s emotional state, including the cultivation of patience, love, attentiveness, and resilience. The second category is to manage the emotional state of the patient or relative. I argue that understanding these elements of caring practice also shows how care is made meaningful only in relational dynamics and thus offers a primary means through which individuals judge the state of their relations (Klaits 2010).

Managing One’s Emotions

Patience

*Mma Puso has cared for her younger brother Jonas since he went blind five years ago. He used to live with his elderly parents at the cattle post, but did not like being in the remote location so he announced to his sister that he would like to live with her. Mma Puso accepted him into her home after he had sought testing and began ART. Jonas brought a food basket subsidy with him into the home. Instead of using the money for food staples, he insisted that she buy him the nicest scented soaps and lotions although this sometimes required that she return to the store after they made a special order. He would become very cross when she did not bring the right products. When Jonas was feeling sick, he would often lose his temper with his sister and niece, using rude language with them and he was frequently picky about the food he ate, sometimes refusing to eat at all. Mma Puso struggled to maintain her composure in these*
instances, but she was used to remaining patient when a sick loved one was rude. She had nursed her husband before he passed away a decade ago and told me that she learned much from that experience.

I discuss the importance of patience first because caregivers emphasized that it was a foundational starting point to cultivate the proper emotions in their caregiving tasks. For instance, Mma Orogile described learning the embodied knowledge of dispositions necessary for caregiving, “I have learned how to handle a patient and how to give them love without losing my patience (mo telele pelo).” Mma Ngake, who also cared for her elderly mother, explained the specific need for patience with one’s elders, “An elderly person when fully grown their mind goes back to being a small child, when I tell her something she will later ask me again.” Her mother also quarreled with her sometimes but she said, “I understand because she is old, I do not get upset. When she refuses to bathe… I talk to her politely and softly until she agrees to bathe.” Mma Tebele, who also cared for an elderly mother, echoed the sentiment of patience in the face of the patient’s rude behavior, “I learned that you have to be patient (letelela) and encourage her, even if she shouts at you, you just have to care for her.” Mma Puso elaborated on the need for patience as a caregiver, “When taking care of a patient, you are supposed to have patience with them and not lose your temper. With a patient, they will just say anything, but you can’t let it get to you. Even when the patient is like that you just continue with whatever you are doing.”

Other caregivers like Mma Lerato linked patience with love and commitment to the relative, as she put it, “My responsibilities in taking care of the patient – the first thing is love, and commitment, which is to say patience. If you give a patient love, give them patience, the patient will love you to the point that they will open up, and their pains will not be as painful as when you yell at them, meaning when you become angry at them.” Mma Lerato offers a very
clear articulation of the deep bodily links between patience, anger, and the physical well-being of the sick. For this reason, caregiver strived to cultivate this emotional state even in the face of a disagreeable patient, to help heal them.

Home-care volunteers also focused on this dynamic as they sought to educate caregivers. Mma Gontle summarized the importance of patience for the patient’s health, “We will even teach them [families] that if a patient is refusing to bathe or eat they should be patient and easy so that the patient’s feelings and health can get better.” She went on to explain that the emotions of the caregiver had powerful effects of the emotional state of their patient as well. She said, “The caregivers are not supposed to be angry. You are supposed to be easy so that the patient will also take it easy. That way the patient won’t be feeling hurt and denied all the time.” As we will see, patience is a crucial practice because it prevents the emergence of anger and scorn, which are considered very dangerous to the bodily well-being of the patient (Klaits 2010; Livingston 2008).

**Love and Compassion**

Love is a key part of caregiving practice, and the expression of love underlies practices such as massage and even visiting. These are actions that “show” love to another person. Cultivating love as an interior state is also a key moral practice because it can contribute to the process of healing. Mma Lerato described the need for love to heal her mother. As she explained,

> You will manage to amuse them [the patient], make them laugh, then they will be happy to be around you… we should not be rude when we are with the patient. Love heals, better than pills. When you give them love in the home, you give them healing. When you treat them badly, you might just shorten their days… Patients really need love in their lives. It may be your mother, child or grandmother. When a person finds themselves in this situation of not being able to do things well, you should love them and take care of them. To take good care of them, you will see your patient in less pain.
This reveals the link between habitual routines and the emotional states that should ideally generate them. As she put it, “If there is commitment and love, these are the things that can teach you how to take care of a patient.”

Larona, who was in her early 20s and cared for an elderly aunt, proposed that love among the family members generated an openness toward the patient that was beneficial, she explained “It’s good that they work together. It is not all the time that you find people helping each other in the home. It you can bring love together, there is openness for the patient.” Mma Rona, who had two adolescent children who helped care for their sister with severe disability described their care in terms of the love they showed, “They give her love just like I do.” She explained the bond that she shared with her daughter created by their reciprocal love, “When I enter the yard, she feels happy. When I am at the gate she can hear that I am arriving.”

Mma Tsholo, who helped run the local chapter of the Red Cross, spoke about love in terms of the central role of the family in caregiving. She explained, “The patients have to know where they belong, so the family plays a big role. Sometimes that person can just heal without medication but just from the affection and the love, support they get from their family.” Love also played a primary role as a moral sentiment that motivated compassionate action outside of the home. Mma Molefe, an elderly volunteer at the Red Cross, explained that “If a person has volunteered, you’ll know that they are not paid but they’ll do their work out of love, just to help patients. It is a very good thing for the country. As a volunteer, you work with your physical body, with your mind, and with love.” Given the importance of this affective state to motivate effective caregiving and moral action, Mma Bana’s indictment of her relatives and the state of relations in general is even more meaningful. She told me, “At present, no one will even help you with love… There is no one left with love, only God.”
Attentiveness

Closely associated with both love and the physical labor of care is the skill of perceiving and attending to the needs of patients when these arise. This reflects the importance that scholars have noticed in the development of attunement as an embodied skill that arises from the practice of care (Hamington 2004). In most cases, caregivers mentioned their ability to notice when their loved-one is not well. Mma Naledi put it simply, “We make sure she wakes up well. If we see that she is not well, we will take her to the clinic.” Mma Lerato elaborated on what this process entailed, “If she [mother] is not well, I am able to realize that she is unhappy. But when she is feeling better like today, I do not have a problem, we work well together. It is just that we cannot have talks. I am the one who can see whether she is well. When she is unhappy, when she is looking pale, that is when I can see she is not well and I can take her to the hospital.”

Mma Buku, who cared for her elder brother, described attending to his well-being as a routine aspect of caregiving. When I asked her to elaborate on how she did this, she explained, “When he is not well, we are able to see that today he is depressed, he did not wake up feeling well. We will see it when he’s not waking up like usual, also when we give him food he won’t eat like we normally see. When he’s not well, he normally cannot eat properly.” This mode of attention arises from both placing that individual as the focus of one’s attention and the familiarity of living with them every day, which makes it possible to perceive when they are not acting in their usual manner.

Caregiver’s critiques of hospital-based care also affirmed the importance of such attentiveness to the well-being of the patient. Mma Gaone, whose adolescent son had both mobility and speech impairments, told me, “When the patient is at home you can look after him better than when he is at the hospital. When he is at the hospital he is not given enough attention.
People there – some are short tempered or negligent. At home, you are closer to the patient, you are always stopping to check how he is doing.” Similarly, Lesego who looked after her uncle, remarked on the increased attention that patients can be given at home, “Here I make sure the patient is clean. I feed the patient, at the hospital they don’t do the same. We give the patient anything he needs when he is at home, much more than when he is at the hospital.” It is the emotional responsiveness of the caregiver at home that distinguishes it from the impersonalized nature of hospital (and therefore professionalized) care. Wrapped up with this attentiveness is patience and openness to the loved-one. This openness also requires a resiliency to the pain and duress that caregivers often face.

Resilience

The emotional skills listed above both contributed to and arose from the resilience of the caregiver, and their ability to recover from difficult circumstances. Emotional pain was a regular feature of the embodied realities of care among interlocutors. Mma Lerato struggled to witness her mother’s suffering during her stroke, “It was tough for me, but because I love my mother I persevered through that. I took her into both my hands with much love. I shed a tear when I saw her in pain, I cried. Even though my tears fell on her I loved her and wanted to help her.” She positions her ability to manage her pain at seeing her mother’s condition by using her love as a resource to help persevere.

Sometimes the pain was not generated by the condition of the patient, but because of strained family dynamics or conflicts that made caregiving difficult. Sara, who helped her grandmother care for her grandfather, recounted to me that the couple had been cut off from their food basket when the orphan grandchildren at home were approved for their own food aid. Now the adolescents oversaw spending the debit points allotted to them each month. Sara explained
that the situation had deteriorated because the youth liked to spend the entire amount on their own food. Sara told me, “It is so painful. If only the old woman or man were on food basket it would be much better.” She explained that every month she had to argue with the children over the food basket,

> I feel very hurt for the old lady because even when she asked the orphans, they will say there is no money left in the card and they will be very aggressive. They will even ask for money from the old woman and man, saying that the school is asking for money for this or that. Then the old lady will be left with nothing. Again, there is nothing we can tell them because the cards are theirs there is nothing we can do about them, they are their responsibility. It’s hard for the old lady especially if the old man wants food, it’s very challenging for us.

Sara navigated this dilemma as best she could, by advocating for the couple and attempting to share food when she was able. Like many instances of family tension, the distribution of limited food aid within the household was a significant source of tension.

Mma Puso explained that it could be painful for her when her brother Jonas was stubborn. As she put it, “What is hurting me is that he is no longer eating, he doesn’t have a good appetite. Some time back he would only eat phaleche [corn meal].” She offered a simple summary of how she dealt with such setbacks when she told me, “I’ve accepted the way we are living our lives, I just cannot see these things as problems. I cannot allow those challenges to hurt me.” What Mma Puso expresses is a tolerance for painful experiences at the heart of caring practice. It was important for caregivers that they cultivate a resilience to these painful realities so that illness, family tension, or stubborn patients did not put them in a depression. As Mma Bana put it, “We must motivate ourselves (ikgothatsa), who else will care for our children?”

Depression and demoralization was a worrisome aspect of care-giving, which is why volunteers reiterated the importance of motivation and encouragement for caregivers. They often found themselves helping the caregiver cope with difficult feelings because they had to make
sure that the caregiver did not “give up,” which could lead the patient to do the same and quicken their death. Mma Molawa explained,

The most important thing the volunteer has to do is to motivate the family member when she gets there. The first thing you do is encourage the caregiver, telling her that this situation is her responsibility so it’s only her to encourage the patient with her. The caregiver is supposed to motivate the patient so that they can get better. I will tell the patient that she should listen to the parent, what the parent is telling her to do so that everything will be well. I will tell her that she should listen, so that she will get better. The most important thing is motivation. I motivate them so that they will know how to comport themselves (itshware).

As Mma Molawa indicates, key to all this process is the ability to comport or restrain one’s emotional state and actions in ways that will create love and heal the patient.

Underlying the cultivation of patience, love, and resilience is the specific demand to regulate one’s emotions when the patient exhibits rude or challenging behavior. Kalafo explained that her uncle could sometimes be obstinate, “If he eats, he eats. He is moody. When you bring him soft porridge he will say he does not want to eat it, he wants bread.” In these situations, caregivers must keep a cool head, which serves to calm and assuage the mood of their patient. This mandate is woven throughout the previous narratives in this section as caregivers speak about maintaining their patience and love even when the patient is in pain or is being obstinate. Mma Lerato expresses the association between such sociable emotions and physical well-being when she said, “When you are getting along well with them, you will see your patient in less pain.” In the following section, I address the process of cultivating or creating emotional states within the patient or loved one, which is a key aspect of care as a “relational” practice.

Managing the Emotions of the Patient

For Home-based Care volunteers, their role required the ability to affect the emotions of patients by instilling hope and the emotional uplift that would allow them to live. Mma Bereki, a volunteer since the first days of the program, explained, “If it’s a patient who is able to assist
herself, or patients who are able to sustain themselves I will talk to them so that they have hope and the feeling that their lives are not over. I will advise the patient that it’s not the end of their life.” She described her role as providing an emotional connection, “I will also pray with her and I am able to ease down their pains in their body. At times, you’ll find that their feelings are very neglected so I will ease them. That is mostly what I do when I am with my patients."

Although this dynamic existed across caregiving households, in certain cases the specific condition of the patient warranted close monitoring of the emotional states of the loved one. Mma Naledi spoke of this when she described her mother’s high blood pressure, “A person with high blood pressure you are supposed to know how to calm that person so that the high blood can go down. Though I will be doing a heavy job, I must know that a person living with high blood pressure doesn’t want excessive noise and also not to be hurt. Like that her BP will go down even before she takes her medication.” She reiterates the potency of specific emotional states to benefit her mother’s body “even before she takes her medication,” reaffirming the moral agency of her responsibility to create this well-being in her mother.

In some cases, caregivers had the additional task of caring for a troublesome or “difficult” patient, which required additional emotional labor. As we’ve seen, caregivers regularly referred to the reality that patients could be rude or stubborn. To return to the example of Kalafo’s uncle, she gave some examples of why he was difficult to work with, “He is a difficult person, because he does not like to wash in the morning, even at times in the evening he refuses to wash saying it’s very cold.” Similarly, Mma Ngake had to manage her mother’s feelings when she tried to correct the old woman’s behavior, “Sometimes after I have bathed her she will say she’s feeling cold, she wants the sun, she normally crawls and dirties her dresses, when I tell her it’s not right she will say I’m challenging her and then she’ll get angry and
annoyed.” As we have already seen, the principle method to manage the frustrations of the patient was to cultivate one’s own emotional expression and behaviors, such as “talking to them softly” until they would “open up” and calm down.

Mma Puso’s daughter Onti also described her uncle Jonas as a difficult person. As Onti told me, “He is not a person who takes other people well. He doesn’t take a person to be human.” She speculated that his rudeness to other people related to the fact that “he has not accepted that he is living with a disability, he hasn’t accepted himself.” Like her daughter, Mma Puso thought Jonas was a “difficult” person due to his pride and resistance to his newly dependent sick role. She explained, “He cannot do anything for himself now. He used to be a builder but now it’s very difficult because he cannot do anything for himself and it’s a problem because he is a big man. He has got his own feelings about things, when he says he does not want something, when he wants it he wants it.” Since he had become bed-ridden, however, she no longer returned home to find him missing. In times of better health, if he had the money he would often up and leave, hiring a taxi to go to the main mall without telling her.

Jonas’ case offers an example of how patients may resist or interrupt the flow of care through refusal to bathe or to eat or to in their desire to “crawl” or move outside. He was only one of many cases, however, in which caregivers attempted to create “self-acceptance” within the patient through their love and attentiveness, because accepting their circumstances would improve their emotional well-being. Some volunteers attempted to encourage this acceptance through prayer, as when Mma Mpopi recounted, “If I see that her feelings are discouraged I will sit with her and say a prayer. The prayer will calm her down so that I can talk to her and tell her that she should accept her illness so that she can get well quickly.”
These cases reveal the continuous emotional labor of caregiving, both in terms of cultivating moral sentiments and avoiding the dangers of depression or “giving up.” Caregivers develop a set of emotional and dispositional skills that both inspire and find their expression in the routines of physical care. Moreover, the management of one’s interior state is not for personal benefit, but to create well-being in the patient and even extend their life. This life-sustaining labor also entails being responsive to the emotions of the patient and creating positive emotions in them through the enactment of one’s own love and patience. For these reasons, which are rooted in the permeability of the body to the emotions of others, I consider caregiving to be a form of “relational” labor.

**Conclusion: Care as Relational Practice**

At the start of this chapter I set out to define care in empirical terms through the narratives of my interlocutors. Doing so revealed an extensive and interrelated set of physical and emotional labors that were united around the ideal of preserving the dignity, social integration, and physical well-being of the patient. The achievement of this state of bodily and relational well-being resists the dichotomy of the physical and emotional, as emotions may either heal or harm the body. I propose that caring labor thus resists the division of physical and affective states, and addresses itself directly to the nexus where these are joined.

Care-giving is inherently relational because it operates at the intersection of bodies and relationships. The obligations of kinship are made material and concrete through acts like bathing and feeding, and the state of the body reflects the strength of kin relations (Klaits 2010; Dahl 2014). This supports Buch’s (2015) assertion that care is both interpersonal practice and a set of crucial labors that sustain life and social reproduction. This reality is reflected in caregivers’ concerns about their patients refusing to eat or bathe, since their condition provides
the evidence of the moral agency of caregivers. The empirical concept of care that emerges is one that exists in the relationship between individuals rather than in single bodies.

This chapter identifies the primary categories of physical labor and of emotional states that are united in the practice of care. I use these to define care as a relational practice comprising both emotional and physical labors that maintain the foundational requirements of personhood and thus express the ethical precepts of social membership and harmonious interpersonal relations. Interlocutors identified the requirements of personhood as sustenance and cleanliness of the body, proper dress, and management of dirt or other bodily substances, as well as a set of loving dispositions that underlie this effort. It is crucial to note, however, that the achievement of these ideals requires significant material and financial inputs, which meant that interlocutors regularly made claims and sought resources from a range of relations (both kin and governmental) to sustain caring practice and survival. In this process, there were many setbacks and frustrations.

Emotional pain and duress appeared during caregiver narratives when the patient was suffering, there was conflict within the family, or they had difficulty meeting the basic needs of the patient. The failure of their relations to provide material resources led caregivers to lament the absence of these relatives and their failure to achieve care. In the next chapter, I elaborate on the gendered dynamics that shape caregiving practice and examine the economic and demographic strategies that women employ within their household. I examine in more depth the narratives of the failure or limitation of care to examine how these emerge from breaches in broader material flows and survival strategies.
Chapter 4: Women’s Distributive Labor and
the Limits of Care

Considering the Failure of Kin-Based Care

In the previous chapter, I demonstrated that caregiving represents an investment of physical and emotional labor that requires significant financial and material inputs. The emotional and physical work of care is also an important ethical undertaking that expresses how people should treat one another and the basic entitlements of all people to dignity, social recognition, and a life without the suffering of hunger and neglect. To begin this chapter and my discussion of the “failure” of care, I share the story of a troublesome case of family neglect that caused a great deal of concern among CHBC volunteers. I do so to highlight the markers of failed or inadequate care among my interlocutors as well as the ambiguity between narratives of ‘absent kin’ and the reality of on-going forms of kin-based support (even in attenuated form).

I first met Mogorosi in 2012 when I accompanied two CHBC volunteers to his yard. They wanted to introduce me to him because they were troubled that he lived alone in a yard in an unfinished house. Mogorosi was 48 years old when we met, and was living with a mental illness that impaired his ability to clearly communicate. He had inherited the yard from his deceased parents and he stayed in an unfinished cinderblock house; he slept in the only room with a roof on a mattress on the concrete floor. The volunteers expressed frustration that his sister (who lived nearby) was not taking proper care of him. The volunteers told me stories of her neglect; specifically, they sometimes found the patient without food, or with a plate of leftovers or scraps, which they considered very disrespectful. The volunteers had pooled together to buy him a small lantern and a radio (to keep him company because he stayed alone), but the items
had disappeared and they suspected that his sister had taken them. They wanted to raise money to install a latrine for him, but the process was slow.

When I returned to visit Mogorosi in 2015, he was in a similar condition, and we found him alone in his yard in mid-morning. We decided to walk about three minutes to a neighboring yard to meet with his sister Boitshepo. Boitshepo offered a very different account of her care work from the volunteers. She sent her brother food every day; her two eldest sons brought it over to him after school and they also sometimes spent the night in his house with him. She oversaw collecting his monthly food ration, since he was not able to do this himself. She managed and cooked the food for her three children and brother as well. When the ration ran out (it could not stretch the whole month for all of them), she used her own income and food from her small garden to feed her brother. She also routinely borrowed small loans from neighborhood groups when she needed food, although she had to pay these back with 20% interest. She tearfully told us that even with the food basket, her small income (she worked part time at a local bar) and borrowing, her family still lived with hunger.

As in other households that I encountered, the tensions between adequate or improper care revolved around food and the use of government resources. The volunteers did not trust that Boitshepo used her brother’s food basket properly. She did not live up to their expectations of care; specifically, she did not bathe him or look after his yard, nor did she keep him company, and they were concerned that he did not get his share of the food. The fact that her brother lived alone made him more “visible” for aid in certain ways. For instance, social workers had started regularly checking on Mogorosi, and were going to build a new latrine in his yard. In only 2 cases of 136 in my sample did we find a patient at home alone during the day. In both cases,
there were still kin in nearby yards. It was rare for someone in Mogorosi’s condition to stay alone, which was cause for concern and government intervention.

The tensions around which kin have control of government resources (such as the food ration) and whether their care entitles them to a share of this support, is a crucial aspect of the conflicting perspectives around the ideals and failures of care. As we will see in this chapter, such tensions occurred even in situations in which the recipients of aid lived with kin caregivers. Yet what this story shows is that claims of neglect – even in this extreme case – were not straightforward. Mogorosi had a sister who managed his food aid, cooked for him, and sent her children to check on him. Kin-based care cannot be said to be utterly failing, therefore, and it continues to provide a basic safety net for patients and the elderly or dependent. What is interesting then, is why and how such care appears to be “failing” to those who sustain it, and the way that material poverty exacerbates (or generates) these anxieties. It is also crucial to understand how on-going forms of interdependence between both giver and recipient of care appear to contribute to these tensions, rather than allay them. I shift now to discuss the broader patterns and survival strategies among my participants to help understand the paradox of kin-based care, which appears to both fail and succeed at the same time.

**Caregiving as Distributive Labor**

In this chapter, I attend to a primary tension that emerged among my interlocutors, in which the ideal expression of care commonly arose as a contrast to the reality of its limitations and short-comings; in other words, to the failure of care. To address this tension, I turn to the framework of empirical ethics (Fassin 2008; Brodwin 2013), which approaches the study of ethics through analysis of the discursive framings of events or actions. To understand the ethics of care, scholars cannot simply show how abstract ethics are emulated in practice; rather, we can best understand ethics as it emerges from everyday life as individuals act and then later provide
an account or rationale for their actions (Das 2012; Fassin 2008). I employ this approach by foregrounding the economic realities and relational strategies amongst caregivers, and the struggles that they experience in everyday life, as the context from which their ethical framings emerge.

I place their narratives of the limits or absence of care in dialogue with survival strategies that are becoming increasingly common in the region so that we can comprehend how ethical breaches of care take shape. I do so first by outlining the importance of resources distribution and caregiving to constitute the interdependence that sustains households. Then I then look at the role that money, specifically, plays in household survival, and how the shortage of money and resources generate anxieties both about and by kin caregivers. Finally, I offer some examples of the family conflicts that exist alongside persistent forms of cooperation and interdependence, which help to make sense of narratives of failed or improper care.

The relational labor of caregivers, as described in the last chapter, is crucial to overall household survival as well as keeping one patient alive and well. The primary caregivers in my study (77% of whom were women) play central roles in securing the networks of resources that keep their household afloat. Ferguson (2015) argues that many Southern Africans are shut out of “productive” wage labor and engage instead in distributive processes, various tasks with the purpose “not to produce goods but to engineer distributions of goods produced elsewhere by accessing and making claims on the resources of others” (90). Those who lack formal jobs must “improvise” contingent livelihoods through a mix of “petty trade, hustling, casual labor, smuggling, prostitution, begging, theft, and seeking help from relatives or lovers, etc” (91). As these activities are designed to secure survival from one moment to the next, it is crucial that we
shift our focus to these forms of survivalist improvisation, or as Ferguson calls it “distributed livelihoods” (94).

These improvisational strategies were ubiquitous among the caregivers I met, and home-based caregiving is a central piece of such arrangements and labor. I therefore foreground the role of caregiving within the distributional labor of women in the village. Rather than separate caregiving labor from the domain of “economic activity,” I use Ferguson’s concept of distributive livelihoods to examine care within the suite of women’s activities that strive to secure access to various flows of resources. This approach centers on women’s labor and the work that sustains interdependence. Establishing small streams of income while also positioning oneself to make claims on the income of others required constant work and maneuvering. The distributional pressures on income streams (both from wages and government transfers) are shaped by obligations to care for one’s relations.

I propose that caregiving is a distributional labor as well as physical and emotional labor for two reasons. First, it shapes the formation of household residence and subsistence in foundational ways. As Ferguson notes, migration in the region is no longer focused mainly on securing employment, but equally on finding a place where “people can care for you,” perhaps with a relative who has an income of some sort (2015, 109). Among my interlocutors, almost everyone had moved in with or brought their patient from another yard to provide care. Second, care work is a form of labor that entitles a caregiver to a share of a relative’s income. For example, most female caregivers living with their elderly parent (usually their mother), would share in her pension money or food basket to feed them both. I also noticed a pattern among grandchildren in their 20s living with grandparents with whom they could exchange bodily care for a share of monthly food and pension resources.
The provision of care has become central to distributive flows because these flows no longer center only around those with access to wage income. Distributive claims are made even on small streams of revenue, such as an old age pension or destitute food basket. This positions those previously derided as “unproductive” or “state dependent,” such as the elderly, sick, and disabled, as key players within distributional flows. Making distributive claims on others entails a lot of “social labor” in relationship building and maintenance, which helps us to reorient our conception of dependence as a passive mode (Bayart and Ellis 2000; Ferguson 2015, 97).

Disability studies diverge from literature on care precisely because care researchers often presume that caregiving is based on dependency, and regularly reclaim autonomy and agency for recipients of care (Kröger 2009). Some scholars (cf. Thomas 1993; Waerness 1984; Ungerson 1990) define care in relation to dependency, in which a person who cannot perform tasks for themselves is simply dependent on their caregiver. Yet the ethics of care, which has become influential in care studies, has gone a long way to emphasize interdependence rather than dependence. For instance, Tronto (1993) and Williams (2001) offer a “universalist” frame that argues vulnerability and mutual dependence are central concerns of all people, not just the elderly or the impaired. This perspective does not negate the realities of different abilities, but prioritizes mutual dependence rather than an independence-dependence binary (Fine and Glendinning 2005). Both care and disability research have converged around interdependence and redefining the concept of autonomy as self-determination to better fit in this framework (Williams 2001).

My research contributes to this discussion in two key ways. First, it illustrates how distributional flows and caregiving labor constitute mutual dependency or interdependence, which are crucial to household survival. Second, it shows that this interdependence is not simply
a universal “given” as theorists suggest; rather, it is plagued with family tensions, anxieties and accusations about money, the perceived absence of support, and ambivalence about the legitimacy of distributional claims. These insights are important to empirically ground theoretical discussions about dependency and care. They also establish the context in which ethical conflicts arise around differing conceptions of dependency and autonomy within the welfare state.

In the next section, I provide an overview of prevalent household strategies built around formal and distributional labor. Then, I attend to the ways in which responsibility for care work adheres to female kin within these arrangements. Following this, I examine the common forms of distributive labor in which my female interlocutors engaged and examine the critiques that began to emerge as women struggled to pull this off. In the final section, I contribute to our scholarly understanding of both empirical ethics of care and distributive labor by arguing that interruptions in flows of money or aid, and conflicts about mutual dependence, contributed in large part to caregiver’s accusations of failed care from both bureaucrats and relatives.

**Demographics of Household labor and Employment**

The demographic profile of my participant households reflects the changing importance of marriage for household formation in Botswana. The decline of marriage rates has led to a burgeoning of female-headed households in the country (Livingston 2005; Ingstad et al. 1992). Across the region, scholars have shown that women are increasingly supporting themselves with distributional strategies independent of a male head of household (Ferguson 2015; Hunter 2010).

In my sample, 60% of households were female-headed. I define “head of household” per the self-identification of my interlocutors; in some cases, this refers to the household’s primary economic earner, while in others it simply reflects the senior matriarch or patriarch of the family regardless of their economic role. Although 40% of households still included a male head of household, this was not exclusively in the role of husband. Only 31% of surveyed households
were founded on a marriage or heterosexual intimate bond. Overall, 29% of households included a married couple living with three generations, and it was very rare to find a “nuclear” arrangement (only 3% of households). Although multiple generations in a single household is not historically unusual, the normative model in the past hundred years has favored young men founding new independent households from their parents at the time of marriage when they accumulate enough wealth (in money or cattle) (Motzafi-Haller 1994). This ideal is far from the contemporary reality, however, because young people now face extremely high unemployment.

In Botswana, as elsewhere in Southern Africa, unemployment rates are permanently high (Chigunta 2017). The national unemployment rate (which includes only those looking for a job) reached a high at 23.8% in 2006, dipping to 20% in 2013, and then falling to 17.8% in 2016 (ibid). According to the African Economic Outlook (AEO) report for Botswana, unemployment is highest in urban villages (25%), which includes Serowe where my research occurred (“Botswana” 2008). Given this persistent unemployment, even during periods of overall economic growth, Botswana has among the highest rate of income inequality in the world (World Bank 2017b).

The household strategies among my participants must be understood in this context. In 51% of surveyed households, at least one resident was employed in a waged position. This reflects broader trends, which indicate that the employed population comprises 50% of the working-age population in the country (World Bank 2015). Unemployment in Botswana reflects differential labor access for men and women, as women have a higher rate of unemployment than men, 23.9% versus 16.4% respectively (ibid). This trend is borne out within my village sample. Among the 54 households with male heads of household, 16% were working for a wage, while from the 82 female-headed households only 10% were formally employed. Given that
access to wage labor is low, many households relied on other forms of income; for instance, 64% of households had at least one resident who received a monthly old age pension from the government. 51% of households were accessing the food basket program every month, although this may have been higher than a general population rate given that the households had at least one patient or elder who was receiving home-based care.

Low employment rates did not mean, however, that household residents were not engaged in income-generating activities. I used the term “self-employment” in my survey instrument to capture the forms of distributional activities that Batswana use to survive. These activities included petty trade/market activity (see Fig. 3), piecemeal domestic labor for others (i.e. washing or cleaning for hire), and short-term *Ipelegeng* (government work relief) placements.

*Figure 3. Informal market stalls were often set up in town centers and around the bus ranks connecting towns. Photo by author.*
50% of the surveyed households included a member engaged in this form of income-generation. Women were more likely to be occupied in this improvisational labor than male household members; only 17% of households included a woman in the formal employment sector, while 36% included women engaged in distributional labor, and 7% relied on both male and female kin to engage in distributional work. Regardless of the gender of the head of household or women’s employment status, within the household female labor played a key sustaining role. Women were primarily responsible for domestic labor, such as child care, cleaning the home, cooking, and washing clothes. 85% of households relied on female kin for such labor, while 7% included both men and women in these roles, and only 7% relied exclusively on male kin.

Given that women were often caregivers, while also engaged in domestic and distributional labor, it is not surprising that they reported that they felt conflicting obligations that pulled them both into and outside of the home. This indicates the importance of the role of mobility for many distributive strategies. How do women cope when survival requires them to be both “at home” giving care and “outside” of the yard earning money? This sense of a double-bind, either being unable to leave the home to work or having to lock the patient in the house alone, was an acute area in which caregivers perceived an absence of aid (we could also say distributive input) from others.

As I indicated in the opening vignette, rarely was this neglect “absolute” or caregivers lacking support networks entirely. For example, in only 9% of surveyed households (12 cases) did the household consist only the caregiver and recipient. In general, the caregivers lived and cooperated with a core group of residents in their yard; the average size of the households in my sample was 6 people. Despite these various strategies, however, many household members
reported a chronic struggle for financial stability and perceived this to be an arena of difficulty. This chronic difficulty served as visceral, material reminders of the “failure” of a larger web of relations, which ideally would secure the basic needs of all persons.

**Responsibility for Care Among Female Kin**

Among surveyed households, caregiving responsibility adhered mainly to female kin, whether the recipient of care was a man or woman. Although caregivers often emphasized that their relatives “were not there” for them, in the following cases, it becomes clear that most caregivers have a small number of key relations to whom they could turn when their own resources ran out. In the following section, I attempt to show which categories of relatives are most commonly called upon for key activities in the care of a loved-one at home. While the primary caregivers were those responsible for intimate care (bathing and dressing, see Chapter 3), more distant relations could be called on for financial assistance with the costs of care. I outline the responsibility assigned to different categories of female relations.

**Parenting/Motherhood**

Of central importance among my family caregivers was the role and duties of parents toward their children. Among surveyed households, 20% of primary caregivers were mothers caring for a child. Although the parenting bond was not always invoked for women specifically, it is telling that there were no surveyed households in which the primary caregiver was a father (though in a few households a father provided back-up care when a woman was working or away from the home). It was more common for mothers to invoke the obligations of parents, especially when the reality of disability gave them long-term responsibility for the care of their children. For instance, Mma Dibela, whose 16-year-old son Thapelo lived with a disability that had left him unable to go to school and in need of permanent care, invoked her parental duty to him:

“Who would care for him except his parents? Because the care is difficult and stressful nobody
else can do it apart from the parent of the child.” Mma Bana, who also cared for adult children with disabilities, invoked a similar rhetorical response when I asked her to define kin responsibilities. She told me,

I did not volunteer, it’s because I am their mother. There is nobody else who can take care of them except me, being their parent. Because I do not have a mother and a father, even my husband also doesn’t have parents so normally the father stays away most of the time because he has to get piece jobs to put food on the table.

Mma Bana and her husband Rra Tshelo were formally married, which put them in a minority of the surveyed households. Rra Tshelo’s role was to be the breadwinner, which he did through a combination of wage work and part-time “piece jobs” as Mma Bana explained, “Their father is a security guard at the schools, so that is the little income he gets to help the family, especially the disabled children. He works in the schools but companies will hire him.”

Children/Daughters

As Livingston (2005) has pointed out, in Botswana moral obligations of care circulate in parent and child relations; the care for a child entitles that parent to care in their old age. Many of my interlocutors were daughters caring for their aging parents; in fact, in 26% of surveyed households the primary caregiver was a daughter, making it the most common bond to absorb caregiving duties. Caregiving by adult children was heavily gendered; only 4% of surveyed households had a son as the primary caregiver. For many of the daughters I spoke to, there existed the perception that they were not getting the help they deserved from their siblings.

Mma Okamela’s mother was 102 years old and required full-time physical care. Although Mma Okamela was one of five children, she alone took in her mother. She explained, “I take care of my mother physically, most of the time I’m only looking at the old age pension to survive. I took her in after all my siblings said they couldn’t manage. I just said, ‘hey, this is my
mother, I will care for her until God takes her from me.’” Interestingly, she went on to explain that she lacked support to care for her mother from her own children. She explained, “Even though you’ll have as many as 20 children, it’s not that they will help or assist you because most of them have their own responsibilities.” She was also disappointed with her siblings, who had all declined to have their mother live with them. She told me, “My siblings said it’s not their responsibility, it’s my responsibility to care for the old lady. Now they’re saying it’s my responsibility to take care of the old lady because I am the one who is ‘eating’ her pension money so it is my problem.” This interpretation reveals an important aspect of distributional tensions surrounding care. Mma Okamela lived with her mother and used her pension to support them both. This legitimized the withdrawal of financial support from her siblings, who believed they did not benefit from a share of their mother’s resources in the same way.

The increased pressure on women to conform to these expectations was expressed in Mma Okamela’s description of her sister’s actions. Her sister, Mma Mopane, lived in the same neighborhood, which made her lack of aid even more glaring. Mma Okamela described this to me, “I even apply it also to Mopane, but she said she cannot manage. But she is the one because she is a woman like me it would have been easy for her and me to take care of our mother. When I am here I am always cooking for my mother, washing her clothes, even now when I’m leaving for a funeral – we have 2 funerals this weekend – there is not enough time for me to bathe her.” This quote reveals both the gendered expectation that it’s easier for women to share in the care of a parent, while at the same time demonstrating that in practice there was no way to consistently enforce this and it often became a point of tension among siblings.

Infrequently, a daughter-in-law would step in to provide care for a spouse’s aging parent. Among surveyed households, only 4% relied on a daughter-in-law as the primary caregiver. This
may reflect a tension in the constitution of households, as participants explained to me that in-laws often tried to avoid the financial and physical responsibility for care of their partner’s parent. In the 6 cases that I encountered where the daughter-in-law had stepped in, this occurred when the biological children lived far away and her husband had brought his parent into his home. For instance, Mma Orogile was taking care of her husband’s grandmother full-time. She told me, “Her grandchildren were interested in me taking care of their mother because they do not stay with her in the village.” The grandchildren continued to bear the financial cost of care, Mma Orogile relied on them sending regular remittances, telling me, “Every month we need money. Sometimes the SmartSwitch [food basket program] money is put on the card late. They also assist me most of the time with the money for transport when we go for check-ups.” In cases of physical distance, the obligation on children did not disappear but transformed into more mobile forms of support, like sending cash to cover shortages.

**Siblings/Sisters**

In addition to siblings trying to sort out care for their elderly parents, brothers and sisters were also often obligated to provide care for each other. For instance, Mma Bana and her household could not survive only on her husband’s income, so she also relied heavily on her eldest daughter. She explained, “When my older daughter remembers us with some money we will buy food, toiletries, to stretch through the month. My daughter is the one who normally gives me money every month to buy food. My other son gives us something once in a while when he can because he’s married. The other child is just a stranger; he doesn’t help us. My husband only gets 1000 pula, which we normally use right away.” The financial assistance from grown children was extremely important to caregiving households and thus tracked closely by the parent trying to organize resources.
Similarly, in Mma Dibela’s household, she drew on assistance from her other children to help with their brother’s care. She explained that she worked during the days so she had to rely on her own sister, her mother, and Thapelo’s younger siblings. She described a broader trend in which forms of mutual aid focused primarily on the co-residents in the yard. She explained, “The people at home are the only ones who can help. Like these kids you see here, these are the ones who help. I spend my day at work.” In this case, the children were too young to work or contribute money so they had to participate in physical care while their mother was away.

In practice, this obligation was heavily gendered, as I encountered 7% of households with a sister as the primary caregiver of a sibling, but none in which a brother cared for a sibling. In one household that I visited, for instance, two elderly sisters were living together. Mma Mogolo, already 82 years old, had moved from outside the village to stay with her bed-ridden sister. Mma Mogolo was too elderly and frail to manage full-time care alone, so she split the duties with her niece, the patients’ daughter, Kgaolang. Mma Mogolo explained the arrangement to me, “I stay with my sister alone. Kgaolang is the one who cooks, with me I’ll make sure I will heat the water on the fire and bathe her, I will also do her washing.” I met Kgaolang when I first visited the old women, but she did not disclose that she stayed with a boyfriend instead of the old women. I only discovered this on a later visit when I found the women there alone. As a daughter, she retained important responsibilities for her mother nonetheless. Kgolang was the only one able to collect the food ration each month, who cooked for both women, and who could still earn money through piece jobs. Thus, Kgaolang although she lived in another yard, still had the responsibility to feed both elderly sisters. The patient’s son Taelo, who lived at the cattle post however, was the one who paid to hook up water access in his mother’s yard. This certainly
represents a significant one-time cost (about 150 USD), but he retained none of the monthly
duties to his mother that his sister had.

Wives

In only 10% of surveyed households did a wife or female partner (I could not verify legal
marriage so I recorded the category given by participants) care for her male spouse. This
indicates that this bond is losing ground relative to mother-daughter roles in providing care at
home. Mma Gorosa’s description of deciding to care for her husband reflects the ambivalences
that characterize intimate domestic relationships in contemporary Botswana. She described to me
the choice to care for her husband although they had previously separated, “Families in
Botswana are not caring for each other – husbands often do not take care of their wives, even
this man himself did not stay at home. Even though he was not staying at home, because of his
health I took care of him. Botswana is full of separations in marriage.” In several cases, the wife
caring for her husband also suffered from poor health in terms of the physical tasks of care. In
these cases, they relied on daughters or granddaughters to share the tasks.

Sara, who lived next to her grandparents and spent her days helping them in their yard,
described the arrangement, “It’s the old woman, his wife, who cares for him and we help her.
She is the one who is able to care for the old man because she bathes him, and us as children we
just help to make sure he has enough food to eat.” Even with the assistance of Sara and her sister,
the elderly couple struggled to get by. Sara explained that they would like to share the
responsibility with the old man’s relations, his “side of the family,” but these relatives were not
interested in contributing. As Sara put it, “There is nobody else to focus on the old man and who
will we give the responsibility to? Like his side of the family are saying that his responsibility is
ours. There is no one else.”
As previously mentioned, not all the spouses engaged in care were legally married. In most cases, the arrangement appeared to work anyway. One case, however, revealed how tenuous these forms of cohabitation could be within the dynamics of extended kin. I met Onametsi, and her male partner Jon, aged 57, at his home after a stroke left him partially paralyzed. They explained that she was his fiancé but he had fallen ill before they could officially marry. She stayed in his yard and the two of them survived from his food basket, but Onametsi also periodically stayed with her parents in their home across the village. Jon did not receive either financial support or caring labor from his natal family. Our conversation became more emotional as Jon tearfully explained that his family refused to recognize her as his wife or assist her with his care. They were worried that at any moment, she could choose to leave him and they believed that she should have no claim to his resources, pension, or house if he passed away. I was struck by this case because of the clarity with which it exposed the marginal position of female partners in Botswana, and because it offers some context for on-going anxieties about co-habitation and rights to distributed resources without formal marriage.

**Extended Female Kin**

Some caregivers reported to me that they could call on ‘distant’ relations for aid in specific situations, as when food in the household ran out. For instance, Mma Okamela, who critiqued her siblings for avoiding their responsibility to her mother, did seek help from a specific aunt. As she explained, “I will go to Basimaneng [ward] where my auntie is and I will tell her we are hungry. I used to rely on her a lot before she went blind. I will ask her for *tsabana* (soybean meal) or *phaleche* so that I can cook for my mother.” This quote is revealing of several dynamics, the first being that despite the discourse of absent relations, caregivers were sometimes still successfully making distributive claims from the extended kin of the patient. The
second important point is the precariousness of such arrangements; in this case, the health of the
aunt and the interruption of this distributive arrangement caused by her own blindness and
change in status to someone in need of care and resources.

During a visit with Mma Ntebela, who cared for her husband, she revealed that she had a
niece who had recently become involved in politics, whom she hoped might be able to use this
position to help secure resources for Mma Ntebela and her ailing husband. She told me, “Dintle
sometimes visits. She is the daughter to my younger sister; her mother is sick like me. She
started working for Botswana Democratic Party recently when they had the elections. She came
here and I heard she was asking whether the old man has been registered [for destitute aid] by
anyone.” In this case, although her niece is not a regular contributor to the household, the
relationship is still open to distributive claims, especially given her new connection to the
government party.

In this section, I have demonstrated that women in various kin relationships play key
roles in sustaining physical care and in the distribution of resources necessary for this work.
Women’s struggles to do so also establish the central tension that emerged; while kinship
relations continue to make possible physical care of loved-ones, those charged with this task
acutely felt an absence or denial of care and support from their relations. If we are to make sense
of this apparent contradiction, we must address the context in which most people use a network
of key relations as the means to secure a living, rather than the possibility of paid labor and
hiring professional care.

Gender, Generation, and Distributive Labor

As mentioned in the previous section, 60% of households in my sample were female-
headed, and only 31% of my total sample included a married couple. Even if there was marriage
within the household, this was most often combined with multi-generational residence. Given the
impact of the HIV epidemic, I also include households missing the middle generation in this
multi-generational category (i.e. grandparents cohabiting with their grandchildren). In total, 56%
of surveyed households included at least three generations, 30% were composed of only female-
kin across multiple generations, while 21% incorporated a married couple. It was very rare for
the multi-generational structure to be based on a single male (grand)parent, this occurred in only
3.6% of the household sample.

Given the salience of this domestic arrangement, I address the way that residence
strategies spanning three generations structure the forms of interdependency within households. I
am interested in how households increasingly pair the distribution of old age or destitute
pensions of older relatives with the informal or piecemeal labor of younger relations to cobble
together a subsistence strategy. Through this lens, we can see the mutual interdependence of
parties that are more commonly recognized as simply “dependent” on the state, i.e. the elderly,
infirm, or unemployed. To illustrate the way that distributive claims are closely bound to
residence and provision of care, I highlight a few representative case studies of common
household strategies below.

**Grandparent/Child cohabitation**

Mma Megolo, aged 72, cared for her husband Rra Megolo (88 years old), who had gone
blind and had increasing difficulty walking. The couple shared their yard with six young adult
granddaughters, spanning from their late teens to mid-20s, none of whom had full-time
employment. The grandchildren were the offspring of the couple’s daughters, one of whom had
passed away and another who was not living in the village. Several of these grandchildren had
their own children under the age of 5 years who also lived in the yard. Although residence
fluctuated, with various (grand)children coming to visit or stay temporarily, at the time of the
survey they estimated that 20 people (including the young children) stayed in the household.

The only granddaughter who worked was a part-time hairdresser, and was not actively
working when I met them because she had recently had a baby. The household relied primarily
on forms of state assistance to survive. Three of the grandchildren qualified for the orphan care
food basket (they were under the age of 20), which could ideally help support the entire
household. This food had become a contentious issue, however, because the youth insisted on
using the aid to purchase their own food rather than food for the elderly couple. The couple’s old
age pensions represented their primary means of subsistence, but their granddaughter Sara
described that the pension did not stretch to meet everyone’s needs. The granddaughters who
were not employed used their labor to help the old woman with the physical tasks of care,
especially Sara and her sister Lesedi, also in her early 20s.

**Three-Generation Female Household**

Mma Naledi was 66 years old and brought her mother, aged 85 years, to her yard so she
could look after her full-time. She also had two unmarried sons in their early 30s living in the
yard, the younger of whom did have a full-time job at a local grocery store. Mma Naledi told me
that she had four other children who had moved away but would visit every month or so, but
only two of these non-resident children were employed. Despite having three (of six) adult
children employed, Mma Naledi described to me that she relied primarily on the combined
pensions of her mother and herself to feed the household residents. The children contributed
when they could; her younger son who worked at the nearby store would purchase food for the
old women after their pension money had run out. The other employed children, one a teacher
and the other a shopkeeper, helped when they were able – although they had their own financial
responsibilities. Much as Ferguson (2015) observed in South Africa, Mma Naledi’s household exemplifies how state distribution programs (in this case pensions) are increasingly taking central roles in survival strategies, even when there is the presence of some formal employment.

**Multi-Generational and Marital Cohabitation**

Mma Dibela, aged 34 and her husband Rra Dibela age 37, lived with their four children (one of whom had a physical disability and was registered in home-based care). The couple also lived with Mma Dibela’s mother and her younger sister, as well as 4 nieces and nephews (whose parents lived outside the village). Mma Dibela worked full-time as a cook for the Health Institute, a vocational school in the village. Mma’s Dibela’s mother and husband made their living from various distributive or self-employment strategies. For instance, her husband grew vegetables in the yard to sell to neighbors. Her younger sister also engaged in piecemeal labor when she could get work doing the “washing” (laundry) for neighbors. This household offers insight into the blend of formal and ‘informal’ or distributional strategies that was common of participant households.

These strategies were even more necessary in that Mma Dibela’s mother was not yet 65 years old and as such did not receive any pension money. In fact, the household was getting by without any form of state assistance. Mma Dibela had repeatedly attempted but been unsuccessful in securing food aid for her disabled son, but her wage labor was not lucrative enough to act as the primary financial support of the family. Instead, the other adult residents had to engage in distributional labor for the household to survive. The “flexible” element of this strategy meant that either her husband, mother, or sister were at home during the day with her son (who was unable to walk or speak). Even with the relatively high number of adults with
various income streams in the home, Mma Dibela felt hurt with the lack of resources for her son from the government.

**Survival and Interdependency**

An especially salient element in these household models is the way that adult children are a resource strategy for their aging (grand)parents, while the government income of those parents has become increasingly important for youth who are underemployed. Although, ideally parents of grown children expect support from them rather than the reverse. Mma Lerato, who cared for her bed-ridden mother, reflected on this process. When she described her economic situation, she told me, “Really, it was painful before my children were grown. Now my children have jobs, they are working and I expect something better from them as time goes on. It is better now since I don’t go hungry.”

Similarly, Mma Gorosa, caring for ailing husband described to me a mix of part-time labor and support from her grown son. She explained to me that, “I survive by working for Ipelegeng, and the allowance of 147 pula, and I have one son. He is the one who can give me P300, only some months. Sometimes he will have problems, as he has a child.” Despite having a son who could earn money, this was a precarious strategy because his obligations pulled him in different generational directions including the care of his own child. Mma Gorosa continued to engage in distributive labor with the help of a government work program. She explained, “Before it was a challenge because I was not able to get piece jobs. Currently I can make the old man food, then I go for piece jobs and I go to Ipelegeng and I am able to do what I need to.”

The mutual interdependence of relatives across different generations was tied up with the harsh reality that many adult children could not afford to offer their parents regular financial support. Botswana’s unemployment rate is 20% among those aged 15 to 35, indicating that unemployment is concentrated among youth in the country (Boikhutso and Molosiwa 2017). It is
even more severe for those aged 18-24 years, estimated to be 33.2% in 2017 (World Bank 2017a). A recent study in the Okavango region indicates that rates may be significantly higher; 57.1% of the youth (between 18-35 years) were unemployed, and women comprised 65.6% of the jobless respondents (Kemiso and Kolawole 2017).

Given the difficulty of securing employment, youth often depended on resources of those in need of care. Sara, the young woman helping her grandmother, described this process, “The biggest challenge is that we are not working. We are only looking at our parents’ pensions because of this. We are able to live with our piece jobs, but the children at times sleep without food, we sleep hungry… When the food is finished, I will know where to ask or where to go – it could be our aunt or her children.” As in Sara’s case, even with cross-generational exchanges of resources (food and pension money) and care, households could find themselves short, meaning that claims must be made to more distant relations.

Female relatives remain the backbone of kinship in Botswana, in caring and domestic roles that have persisted through a generalized and fatal epidemic, years of labor migration and economic transformation, and the changing status of marriage within society. They do so with flexible relational strategies, and by weaving together a complex web of resources and diverse short-term labor, which both participants and my research assistants referred to as “hustling.” I now turn to women’s own descriptions of these activities with an interest in how they frame the problems or difficulties in caregiving that distributive strategies may produce.

**Work and the Limits of Distributional Strategies**

**Earning Money**

I anchor my participants’ strategies and the trade-offs they identify within the reality that securing money is a necessity not only for proper care, but household survival. Since half of caregiving households in my sample did not have wage employment, the pursuit of cash income
encompasses “self-employment,” as well as piece jobs, and government part-time work programs like Ipelegeng. Self-employment was a catch-all term for those who engaged in petty trade activities, including selling phone airtime, produce, cigarettes, or sweets, either from home or in one of the market spaces in the village. For women, this form of employment also encompassed skills like sewing or baking bread to make money from home. On the continuum of part-time work, “piece jobs” referred to jobs done for immediate cash primarily in terms of domestic labor such as washing laundry, sweeping the yard, or cleaning the homes of neighbors, although it might also include being paid to do hair for clients or friends. While men also engaged in this form of piece work, they tended to focus on different sets of skills, for instance hiring themselves out as mechanics, builders, or for electronics repair.

**Piece Jobs**

Mma Tebele described to me that despite having grown children, she continued to rely on piecemeal domestic work, as she put it, “I have children but they are married. We [my mother and I] only survive on our monthly pension. Sometimes I have to live by cleaning the yards for people to get a little money.” Across the village, I spoke with Dimpho, who regularly visited and helped her mother care for her father, and she put the situation more bluntly when I asked how they survived. She answered, “Those of us who you see here, we just hustle. When we have some money, we will collect it together and buy something.” She was referring to the unit of herself, her younger brother and the elderly parents (who supported the household with their pension money).

Mma Puso, a caregiver for her younger brother, earned a small allowance from Home-Based Care volunteering, making 200 pula ($20 USD) per month. Like several other HBC volunteers, Mma Puso supplemented the volunteer income with other economic activities. She
sold food outside of a grocery store in the center of town. She also survived with government food aid given to her younger brother and with the occasional support of her working children. She described this complex mix of activities in terms of having enough food to eat. She told me,

The food basket is not enough for the house. The children will not help every month; they will only do it once in a while when they can. So we will eat whatever we have, what God has given us. We will eat little bits and leave some food at home when I have gone to sell. For seshabo [meat] we will eat anything. When I get the 200 pula from home based care I buy what food I can with it. It’s better now that I am able to sit and sell something by Shoprite. Before I would just sit at home because I was not well.

As in Mma Puso’s case, the time she needed to recover put economic pressure on her household. It was a common occurrence for these improvisational strategies to be interrupted by illnesses, movement of people, or the inability to keep work. For instance, Mma Keletso described the difficulty that she and her daughter Keeya (who was living with HIV) faced in finding income. Mma Keletso had pursued several small trade options until her own health declined (She required knee surgery). She told me, “I used to build Setswana houses for people, making clothes and working as a domestic worker at the school. I left the job in 2002 because I was sick. Now my daughter, ever since she has had these wounds, people are stigmatizing her because the wounds are taking too long to heal and they are all over the body, so she is not able to work.”

Boikanyo and Sarona, two siblings in their 20s, also cycled through various jobs as they looked for secure work. Sarona told me, “I used to work at a salon but it’s a month since I stopped, I would use the money from that for food.” The salon had gone under as there is a lot of competition among these establishments. Sarona went on to tell me her brother now supported them, saying, “My brother is a wood carver, at times he will sell what he makes for money to assist.” It was a challenge for Boikanyo to find customers and he was not registered with any organization to help him sell his work. In many cases, he had to sell items like carved spoons or
bowls for as little as 10 pula ($1 USD). Boikanyo, as a young Basarwa man, could only easily find work as a low-paid cattle minder in rural areas. These jobs commonly went to Basarwa men and often paid as little as 300-500 pula per month ($30-50 USD).

**Ipelegeng**

The government public works program *Ipelegeng* was also a common strategy to earn a little cash among caregivers. It was popular for several reasons; the work was part-time (from 7am to 1pm during the week) but it included a daily meal and a monthly stipend of 500 pula. The program was not a magic bullet. It was not able to keep up with demand from residents; each month people had to “re-apply” and the work spaces were filled on a rotating basis. This meant waiting in a long line early in the morning at the start of the month to see if you would work that month. It was often the case that people could earn money one month and then have to wait one or two more before they were eligible again. Given these circumstances, I often heard about *Ipelegeng* work as part of a larger set of distributive strategies.

For instance, Mma Dikeledi lived with her elderly mother and managed her mother’s pension every month, but described how the two women could not survive on the pension alone. She told me, “We are just struggling, I have been working for *Ipelegeng* project, because there is nowhere else I can get any money… I have one child here who is not working, but the others do not stay in Serowe, and I am the only one taking care of the family.” Similarly, Mma Sego lived with her mother and the two women shared her mother’s destitute food basket. Mma Sego explained however that, “She has been given the food before she was ill, before I stayed with her. Now, the illness has arrived and there is nothing I can do. I work for *Ipelegeng*, after work I come find her at home, sometimes she is helped by a kid [a neighbor].”

Mma Ngake, also caring for an elderly mother, had not joined *Ipelegeng* because she did...
not want to leave her mother without care. In fact, she mentioned her desire to work for *Ipelegeng* if only her relatives might assist with her mother. As she put it, “The only thing I could ask from my relatives is to help me now so that I can register to Ipelegeng just for one month so that I can work. Later I can go and roof my hut or do something, whatever I can do.”

Another set-back that some caregivers faced was the nature of the work within *Ipelegeng*, which entailed clean-up of roads and wards (e.g. garbage pickup and sweeping), or building government houses. Bontle, who managed ART for her son and herself, described her dilemma, “Sometimes I try to register myself to work for *Ipelegeng* and the job is too heavy for me, then I am absent from work because I am not feeling well so this makes life very difficult for me.” Bontle had chosen to seek other forms of part-time work by becoming involved in her local village development committee (VDC). She was elected by fellow residents and attended monthly VDC meetings and supervised the *Ipelegeng* work groups. Bontle explained that, although the pay was irregular, it was work that she was more equipped to handle physically. She told me, “Usually when we [VDC] have a meeting they give us some money. Like last month I was a supervisor for Ipelegeng, but we are 10 members so we keep on shifting, sometimes you are in sometimes you are out. Sometimes you take 3 months as labor, working like any other person in *Ipelegeng*, not being a supervisor.” The demand for those supervisory positions (which would entail the monthly income of 500 pula) among VDC representatives speaks to the ways in which even these forms of civic structures were part of a distributive logic of survival for many Batswana.

**Care and Distributive Trade-offs**

I now turn to the important ways in which caring labor can come into tension with other distributional strategies that require working outside of the home. Some women expressed their struggle with the conflicting demands to be physically present in the home while also seeking the
money needed to keep the household afloat. Mma Bana, for instance, was very articulate about this dilemma. She described the pull she felt to stay at home and keep an eye on her two disabled children. She explained, “Because two of them are always together, I have to see that I am there. When I am not there they quarrel and have misunderstandings, sometimes they fight. Normally I do not want to leave them on their own, so these are difficult things.” She was tied to the domestic space of care, which meant she relied heavily on her eldest daughter Gloria who worked full time as a teacher in the north of the country. She told me, “Gloria is the one who is helping us, at times when she is visiting us, she’ll buy a few groceries. She will also give them her old clothes because there is nothing I can do. I cannot even go to the lands [to farm]. I am always stuck here taking care of them.”

Mma Bana felt the need to stay in the home with her dependent children also disrupted her ability to take advantage of poverty alleviation programs from the government. She described her interest in the small livestock program through the Ministry of Agriculture, which provided successful applicants with goats or poultry to help them sustain themselves at home. Mma Bana was clear that she wanted to use this program, but the demands for her care-giving impeded her. She told me, “The difficulty is that if I took part in the programs I would be able to put food on the table, but the challenges are you need enough time for the programs. For instance, the program for goats they need to know where you will keep the stock and that you are going to be there. I have a problem because most of the time I am with my children and I won’t be able to go to the lands to do the goat program.”

Mma Ngake, who lived with her elderly mother, echoed this dilemma when she described the challenges she was having in applying for the goat livestock. She held the title to a small farm in a small nearby village called Serule, and this is where the agriculture department staff
wanted her to keep the goats, they had even tried to transfer her application to the Serule office. Mma Ngake explained her frustration with the mobility that the agents were demanding of her. She said, “I meant to go to them [agriculture office] this week to tell them I cannot be going back and forth to Serule. I will go back to once they have replied to me that I can come and take the goats because then I will know that I’ll be going to Serule for a longer time, some days or months. Now I cannot be going up and down because it becomes a challenge for me to be leaving my mother alone.”

The demands for caring labor conflicted with other agricultural strategies among my participants. Mma Tsweu, aged 70, was caring for her husband Rra Tsweu, aged 85, with the help of her granddaughters. Their grandchildren lived with them but were not interested in ploughing for the couple. Mma Tsweu was still constrained from the ability to plough for subsistence of the household by her husband’s care and her own deteriorating health. She explained to me that despite her desire to grow food, “I have difficulties because we did not have money for seeds or to pay a person to plough for us. Also, the sickness of me and my husband made it so that we cannot plough at all. The children refuse to go and plough. Even here at home they refuse to plough.” This was a comment sentiment among my elder interlocutors that the younger generation (under 30) were not interested in ploughing or agricultural work and preferred to look for work options in the village or towns. I only met one young Motswana man who wanted to start a farm; otherwise the young labor on farms and cattle posts tended to be Zimbabwean migrants or Basarwa men, probably contributing to its stigmatized status.

Mma Lerato worked part-time and cared for her mother at home. This led to a trade-off that many caregivers discussed as the necessary but uncomfortable reality of leaving a patient locked alone in the home. Mma Lerato’s elderly mother could not walk or move on her own so
Mma described the process of getting her comfortable for the day, “I put her down here on the chair and then I take the chair and put her on it, that way she can relax, to avoid leaving her alone and bored. Now the challenge for me when I go to work and lock her inside the house, is that it is a sad thing because no one can stay with her.” This demonstrates the irreconcilable obligations that women often shoulder, both to provide loving attentiveness in the home and to earn money.

The pressing need for income took caregivers like Mma Lerato physically away from her mother. Even in households without formal employment, caregivers expressed frustration that they could not find anyone to stay with the patient, which would allow them to leave the house for necessary errands. For instance, Mma Okamela stayed with one daughter who had recently finished her school and was starting a new job. This meant that her daughter was rarely at home during the day, which left Mma Okamela in a bind. As she explained,

I will have to lock my mother in the house, because now she can crawl. If I don’t lock her, she will crawl outside naked. Normally I will tell her that I am going to buy some meat or something, and then I lock. Last time when I was at a funeral with her nephews and nieces I told them that I cannot even go to church or to the lands [the family farm], because there is nobody to help me with the patient. I also told them that even when I go for my check-ups I must lock her in and at times I won’t be able to come back until around 2 in the afternoon.

Mma Okamela had recently started to work for Ipelegeng to supplement her pension money and this meant even greater frequency of leaving her mother home alone. She told me, “Now with Ipelegeng, I go every morning and come back at 1pm. I will have to lock her when I go to work, and there are days when I work far and get home late.” The act of leaving an elder alone and locked in caused caregivers a great deal of stress, and made it very apparent to them that the relatives within their kin network were not physically present to help them out of this bind.

These conflicts, in which women felt they must choose between either money for food or sacrifice the quality of care, generated frustrations with kin and bureaucrats that emerged as
ethical critiques. This intersection of moral reciprocity of caregiving and the economic context of survival is extremely relevant to help illuminate why interlocutors made ethical claims about the failure of care. In the following section, I examine in more depth the ways caregivers’ identification of the “limits of care,” and the absence of kin, also relate to tensions around access to distributed resources. In addition, I explore the ways in which caregivers come to see encounters with social workers and other state agents as neglectful or uncaring through a similar framework.

**Empirical Ethics of the Limits of Care**

**Family Tensions**

I heard many stories from caregivers about absent relatives and strained family relations. In the context of distributional strategies, this perspective has less to do with a total absence or disconnection from kin than with denials of distributional claims on various grounds. In fact, relatives may seem more neglectful when they are not physically absent; if they live nearby, but they do not contribute food or money, this denial seems more acute. Mma Ngake’s case illustrates this dynamic. She lives with and cares for her bed-ridden mother since her mother moved from the cattle post in 1998, when she had a stroke and started physiotherapy. Over time her mother’s health worsened and Mma Ngake took over all the routines of bathing, feeding, and dressing her mother.

Most of her find the help from her siblings to be severely lacking, but she focused her critiques on her sisters. She was particularly frustrated with her sister who lived only a few houses away. Mma Ngake told me,

> There are four of us siblings. Her other daughter stays in this yard next to us, but she will only come and say hello without helping with anything. How is she related to the old lady? She is truly her child but she will only come to say hello. Even when I go to funerals or church conferences I will be wondering what will the old lady be left eating. When I tell her [my sister] that my mother is hungry
and she does not have any *seshabo* (meat), she will just say she does not have money. Only once in a while, that’s when she will cook and serve food for the old woman.

Mma Ngake’s question hits at the heart of the interrelatedness and care. Although her sister will contribute food to her mother’s care “once in a while,” she is not performing her relatedness properly. Tensions around money also play an important role in Mma Ngake’s critiques, especially of her other sister. The old woman is registered for the destitute food basket, with an authorization for the eldest child to collect the food. The eldest daughter refused to sign over the authorization to Mma Ngake, who can only collect the food if she is physically with her mother (rather than on her behalf). This means that once a month, Mma Ngake must order a taxi and pay round trip fare to take her mother to the store, while the siblings are arguing amongst themselves whether her name should be on the form. Even with all this effort of collecting the food, the rations will not stretch the entire month and Mma Ngake supplements it with *Ipelegeng* money or contributions from her own children. Her on-going struggle to secure adequate food, paired with the refusal of her sisters to help materially, contributes to the tensions that produce her narrative of absent relations of care.

This was not the only instance of acute frustration with relatives. For instance, Mma Bana was caring for two adult children with disabilities at home. She routinely appealed for help for her children and grandchildren. Her siblings and her husband’s kin had refused to chip in. She condemned her relatives, “My child, at present, not even your own mother’s child will help you with love. Because they are left to watch the changes of the present. There is no one left with love, just God. Now we don’t call each other relatives, their only duty is to laugh at you, backbite and call you your ‘mother’s child’... They are not there for us.” I heard a similar refrain many
times when I asked whether caregivers received help from their kin, most commonly the statement that “they are not there,” or “there is no one.” (*Ga gona ope*).

In the cases that family caregivers did try to account for these failings, it was often by remarking that their relatives were responsible for their own spouse and children. For instance, Bontle who was caring for her young son, remarked to me, “I only have a brother, but he is married so it is difficult for him to help me because he has his own family to look after. But sometimes he can help.” Bontle also recognized that economic conditions made life more difficult for everyone and thus hampered the distributive claims upon which caregivers relied. She explained, “A long time back, people were very cooperative. If someone had something he could share with you. Nowadays every man is for himself. I think the main problem is that our economy is in bad shape so it is difficult.” Indeed, insecure material means not only generate the appeals for distributed resources, but also underlie many of the refusals, a trend that may be exacerbated when the person asking already has access to pension or food aid.

My research demonstrates the importance of examining the material conditions that support or limit the practice of care. I attend to the ways that care is turned into a problem when caregiver struggle to achieve an ideal of proper nourishment and a dignified life. When these material needs become a challenge to caregivers, or when kin withdraw resources due to government aid, this leads to an assessment and accusation of inadequate or absent care. Distributional relations are the context that allows caregivers to pinpoint who is held responsible for such shortcomings. Not only does it allow caregivers to articulate the strain they perceive within familial relations but it also shapes their interpretation of their relationship with state representatives. Specifically, the failure of bureaucrats and relatives to participate in distributive
appeals made by caregivers leads to the ethical claims that relatives are no longer there for each other and of bureaucrats denying rightful aid to citizens.

**Social Workers**

The difficulties of accessing state benefits for distributive strategies also generated targeted critiques of the social workers who act as gatekeepers to such aid. I spoke with Boikanyo and his sister Sarona at length on the topic of local social workers. The young siblings, who identified as “destitute” and were unemployed, made regular attempts to register for aid from their assigned social worker. Boikanyo described that they had never been helped in part due to the personality of the social worker, “She is not someone who likes to help people and she is never in a good mood. I remember when me, my younger sister, and aunt went to talk to them to tell them that we are not living properly, she just said, ‘There is nothing we can help you with so it’s up to you to see what you can do for yourselves.’”

Mma Dibela, a woman whose eldest son lived with a disability that left him unable to speak or walk, told me she spent years trying to get assistance from government social workers. Different officers sent her back and forth between different offices in the hospitals and the community, and told her that her son’s disability did not automatically qualify him for aid. When I asked if she knew where she might go ask for help with replacing her son’s broken wheelchair, she told me “For me now, there are no people I can interact with to help me. It’s because they discourage me, because they are people who do not care for him. That’s why I don’t have the motivation to talk to them, even with them they won’t talk to us nicely, and me I do not want to be hurt.”

Mma Rona also cared for a child with disabilities and she described the lingering effects of negative interactions with her local social worker. She had repeatedly sought a food basket for
her adolescent daughter, who could not walk or speak. She said, “I am still scarred from the social worker, because she is not helping her – they just neglected her. The home-based care volunteers are helping her with things that she needs when they are able, because they visit. The social workers never visit. I have not spoken to the social worker again. It just hurt me, and I moved on.” The words of these mothers highlight another important element in the limits of care, that the denial of care is clearly perceived in neglectful or harsh speech, and very painful for the women. The absence (just like the presence) of care, is marked by the entanglement of material and emotional domains.

Rra and Mma Tshweu, whose story I shared in the introductory chapter, wanted assistance with a new house for the old man. The couple had several run-ins with their local social worker. Mma Tshweu described her experience:

The woman says she’s not the one who build houses for people. The time we wanted her to assess the old man for the food basket, she was very difficult. She was refusing to write down the old man until I quarreled and exchanged words with her. Only then would she write the old man’s name down. I used to lead the old man almost every day to Makolojwane ward [location of the social work office] to try and get him food and they would just tell me “We don’t know him.”

For family caregivers, these critiques reflect the ways in which care is perceived as present or absent through both interpersonal dynamics and the aid furnished from these relations. The rude treatment and refusal of government aid by the state’s agents was evidence of the denial of care, as was the refusal of kin to provide social support or assist with physical labor.

Conclusion
In this chapter, I have been concerned with illustrating how distributional labor relates to residential strategies and the organization of care in profound ways. The interdependence of generations for both state benefits and access to cash is centered around the reciprocity of caring labor. For instance, (grand)children without employment may put their labor toward caring for
an elderly relative whose pension or food basket they can now share. Yet even within these webs of interdependence, the primary caregivers (typically female kin) often found themselves shouldering conflicting demands for their labor. It was hard to balance caring labor with forms of work outside of the home. Women often described a “double-bind” in which they must choose between earning money for food or providing proper care. This generated significant frustrations about insufficient aid from either kin or government agents to help them achieve care. This frustration occurred alongside tensions between households; siblings could use the caregiver’s share of government pensions as a reason to withdraw their own resources from the care of the elder. The friction between a “moral economy” based on reciprocity and flows of care (Livingston 2008) and the “money” economy of subsistence and survival generates the context in which I unpack ethical claims about the failure of care.

I argue that the economic strategies outlined in the first sections provide the material conditions that give shape to the empirical ethics of care. They do so by way of setting the circumstances in which successful care may (or may not) be achieved and the forms of ethical critique that emerge when it fails. Caregivers felt that their attempts to achieve an ideal of care were circumscribed by inadequate financial means and unhelpful relatives and bureaucrats. Rather than sideline economic relations or strategies as an encroachment or corruption of the ethical domain of care, I follow Zelizer’s (2009) insight that money and financial exchange is an inherent part of constituting intimate relations. As Zelizer suggests, “In negotiating economic conditions of care, participants are also defining meaningful social relations” (2009, 207). In this case, they are also using financial flows (or lack thereof) to define the dissolution of relations.

An empirical approach to the ethics of care illuminates how practices and definitions of care are entwined with distributional practices underpinning interdependence and survival in
Botswana. My data indicates that female kin continue to bear the greatest responsibility for caregiving labor, primarily in their roles as mothers, daughters, and wives. Women often cooperate to manage these demands. Participant households rarely comprised only a caregiver and patient, and most co-residents were incorporated in the cooperative unit of caregiving and distributive survival. The pattern of household demographics complicates our common-sense understandings of dependency as many households were characterized by interdependent strategies among different generations. Despite the ability of these strategies to mitigate the worst aspects of poverty and food insecurity, women often expressed the conflict between the various obligations that they had to shoulder at once. The also continued to face food insecurity and financial struggles to meet the ideals of care to which they ascribed.

The frustrations within these strategies reveal that the ethical values attached to care do not exist in an abstract realm; they emerge in practice as care is achieved in precarious and contingent ways. Securing basic resources required constant effort both in terms of wage labor and cultivating relations, often with setbacks and disappointment within these relations. The “paradox” of kin-based care, which appears to be both failing and sustaining care at once, emerges in the struggle to meet one’s obligations while making appeals to a range of relations. Although my sample reveals that groups of relatives continue to form household bonds, their insecure survival strategies often mean that subsistence and care is not a fait-accompli, but a precarious project, which generates tensions and accusations along the way.

As distributive mechanisms become key to survival in Southern Africa, care and caring labor take on increasingly prominent roles in the debates over government distribution and public versus private responsibility for citizen welfare. In the following chapter, I define the model of bureaucratic care in Botswana by examining the underlying values and implementation
of the local social safety net within the village. I use the case of CHBC to illustrate the goals and values of such interventions, and to reveal the significant disciplinary apparatus that comes with the distribution of government aid. This will allow me to further develop the lens of empirical ethics by demonstrating the significant contrasts in the ethics of care between citizens and bureaucrats.
Chapter 5: Bureaucratic Care and the Village Safety Net

In the previous two chapters, I have examined how family caregivers define care and the ways in which they articulate anxieties and setbacks surrounding ideal care, emerging from the material and relational context of survival. I now pivot in my analysis to explore the roles and narratives of actors associated with state offices who distribute crucial resources to households and thus play a central role in care-giving practice. My goal in this chapter is to define the engagement of the state (through the narratives of its representatives) with caregiving relations and practice in the village. I identify and define these forms of engagement as a specific mode of “bureaucratic care” (Stevenson 2014) that characterizes the institutional responses of the government of Botswana. Bureaucratic care structures the attitudes and policies of the State and its agents as they work to define legitimate need and resource provision.

I propose that government interventions at the local level demonstrate a mode of bureaucratic care that specifically targets the relational nexus of care rather than separating the individual from his or her social milieu. This has several important consequences; first, state agents are drawn into relational critiques of absent or failed care in a way that blurs their responsibility with those of kin or domestic networks. Second, bureaucratic care takes on disciplinary aspects in this relational form, which transforms care into a practice and rhetoric central to the power dynamics between government offices and citizens.

The welfare-based “caring state” (Leira 1994) model that Botswana has pursued since independence has made provisioning and bodily well-being a matter of both household and government responsibility (Dahl 2014; Livingston 2005). Indeed, the government funds a suite of programs designed to assist those in need with basic resources; including a national old age
pension scheme, “food basket” benefit program (using a SmartSwitch card, see Fig. 4), aid for orphans and vulnerable children, and CHBC. Among caregiving households in my study, 48% accessed the food baskets and 60% drew on the old age pensions, thus such programs were often as important as wage employment to household survival. Given that many in Southern Africa (and elsewhere in the Global South) are now redundant or unnecessary labor in the global economy, the role of government provision to support their subsistence will likely generate increasing emphasis and debate (Ferguson 2015). This chapter is positioned at the intersection of this emerging reality and the analysis of the “real workings” of states and public bureaucracies in African countries (Bierschenk and Sardan 2014, 3).

I begin by defining the concept of bureaucratic care in practice in Botswana. I then discuss Community Home-Based Care (CHBC) as a case study to illustrate the implementation of a government intervention on social and material relations of care at the local level. CHBC initiated a renegotiation of the boundaries of privacy and expanded a role of representatives of the state within the domestic sphere of caring labor. CHBC, with other aid program, brings government offices into the web of resources for distributive livelihoods and makes its representatives (especially social workers) key gatekeepers to such aid. When their claims fail, caregivers are quick to blame the agents who denied them care or delayed the aid that they need.
Defining Bureaucratic Care

Stevenson (2014) proposes that the ethnographic study of care should attend not only to everyday forms of care, but also to the bureaucratic care that structures government attitudes and policies toward recipients of care. She defines care as the “way in which someone comes to matter” and the corresponding means of attending to that someone (3). Yet people (and populations) come to matter to a government for many reasons, which makes it possible to talk about the ambivalence of bureaucratic care and its unintended outcomes. In Botswana, which some scholars refer to as the “African Miracle” for its welfare-led model, the quality of life of citizens has mattered to government agents for decades (Samatar 1999; Livingston 2009; Saugestad 2001). The process of care-giving relations coming to “matter” to the state, however, has taken increased prominence in the past three decades as the HIV epidemic threatened the nation and social reproduction overall.

In this chapter, I use the term state agent and bureaucrat interchangeably to refer to interlocutors who were: 1) employed or paid by the state (social workers, CHBC volunteers), or 2) elected at the local level as representatives (district councilors, VDC). Somewhat unexpectedly, the employees or volunteers of local NGO also fall into this category, because every NGO in the village operated as a “parastatal” organization, working closely with and receiving annual funding from the Office of the President or Ministry of Health. Through the lens of bureaucratic care, these agents carry out the response to those who “matter” in government policy. In their own terms, bureaucrats ensure that all Batswana citizens “live well.”

Among many interlocutors, the care-giving role of government was explicit. Rra Bothusi, in his eleventh year as a district councilor, explained this to me in terms of the rights of Batswana, “Any citizen of the country, the government is supposed to care for them.” He elaborated further, “The responsibility to care for people starts with the government, from there it
is our role to work with the family members, as well as the committees who have volunteers.” This illustrates both the essential role of the government to care for individuals, but also the ways in which this responsibility is shared across a network overseen by government efforts. Other officers further distinguished this mode of bureaucratic care from other countries by attributing moral sentiments to government efforts (such as sympathy). Rra Sego, a councillor his second term, described this distinction, “Our government is not like other countries because when we started (independence) the government really felt sympathy for us. When it had rained, you’ll find someone asking can I plough for you so you can sustain yourself. They still have that kind of mentality, they have compassion (kutlwelobothoko) for others.” His words mimic the association offered by family caregivers between caring sentiments like compassion and concrete actions, such as assistance programs for ploughing. Rra Sego emphasized continuity in this compassionate approach with the example of the current president Ian Khama. He offered the example of Khama’s actions as proof of caring sentiments, recounting the president crosses the country to visit people where they live, even in the remotest areas (the lands and cattle post are remote and outside of the villages). He explained, “Our current president will even go to check people (go cheka) at the cattlepost, asking ‘How are you living? how do you feel?’ even at the lands (ko masimo). He checks all over the country, which is very good.” Although I was cautioned by a few politicians against identifying the state only with the president, it was a repeated occurrence among my interlocutors. This statement offers a key example of the actions and intentions of the president representing the caring response of the government overall to the lives and situation of all Batswana.

Elected officials (councilors) focused on the broad caring role of the government overall, while social workers, tasked with assessing and implementing aid programs, tended to be
narrower in their definition of care. Mma Tumisang, whom I met in her office located in a modest cinder-block structure next to the kgotla in the center of the ward, was still a young woman. She had worked as a community development officer for about 6 years when we met, which meant that she specialized in assessment for generalized claims in the area, usually distributing destitute aid and orphan packages. Her duties also entailed dispensing funeral packages to those who qualified, which subsidized the cost of the casket and mortuary fees.

She came into routine contact with CHBC families as well; it was her role to assess the families for additional needs after they were registered in the program. Mma Tumisang would make a home visit to conduct the assessment in person, and decide if the family would be given supplementary aid like the food basket. Her definition of care thus encompassed both medical and relational well-being, or as she put it, care means “a lot of support from the family members and getting medical attention.” In the frame of bureaucratic care, I argue that Mma Tumisang and the other social work officers did not simply target a person who matters, but key relations that matter – the relations of care and kinship within the household. For example, Mma Tumisang tied her duties to both an ethos of development (improving livelihoods) and cultivating specific kinship relations. She told me, “Really our responsibility is broad because I believe our task is to develop the community and to enforce a sense that people should live in peace (ka kutlwano) together at home.”

The words of bureaucrats like Mma Tumisang reflects another important dynamic at the heart of bureaucratic care; a disciplinary undercurrent that seeks to care by teaching people how to live properly. This is implicit in her words “to develop” or to improve and advance citizens, as well as to “enforce” the importance of harmonious relationships. The disciplinary element of bureaucratic care also provides an interpretive system for the actions and subjectivities that
interrupt ideal provision of aid, and plays a central role in the empirical ethics of state agents that I explore in the following chapter. As Mma Tumisang indicates, the idea that government actors should intervene on household relations is quite ordinary. I contextualize this common-sense assertion within institutional and historical practices. In the next section, I turn to the case of Community Home Based Care as an illustration of how the government of Botswana specifically targeted the nexus of relations that sustain bodies as well as embedding ideologies of government responsibility for shaping citizen-subjects.

**Case Study: Community Home Based Care**

Anthropological engagements with bureaucratic care commonly focus on humanitarian aid and the biopolitics of managing sick or suffering bodies (Ticktin 2011; Fassin 2007; 2011; Redfield 2013; Stevenson 2014). Scholars describe interventions that are concerned with separating the population of the sick or suffering from their social nexus; in the case of the Inuit, by literally shipping them south away from their families (Stevenson 2014). Literature on humanitarian care has focused on the individualizing force of biomedical models of care within political frameworks of non-governmental interventions such as Medicines Sans Frontier (MSF) (Fassin 2007, 2011; Redfield 2013, 2015). In some instances, these medicalized responses to suffering have led to dissolution of household care and to new forms of abandonment by kin (Han 2012; Biehl 2012).

Conversely, CHBC offers a setting in which to examine a different mode of bureaucratic care, one that is not only concerned with an individual who matters because they are sick. Rather, this mode of bureaucratic care also targets the relational labor that sustains the sick person. This dual medical-relational approach reflects the Tswana ethical logic of *Botho* (mutual humanity) that an individual body can only achieve well-being within a set of loving relationships (Livingston 2008) that I explored in depth in Chapter 3. I briefly review the history
Before turning to the narratives of participants to examine the ways in which the intervention shifted roles and responsibility for care between family and state actors.

**History of CHBC**

The national government implemented CHBC in 1996 during the HIV and AIDS crisis to provide support to family caregivers of the sick who were discharged from overflowing hospitals (Ministry of Health 1996). The Ministry of Health developed two CHBC pilot programs in 1990 and oversaw the national roll-out of the program in 1996 (Browning 2009; Kang’ethe 2014). According to my interlocutors, the program began to recruit volunteers in Serowe in 1998. Village clinic staff recruited and connected local volunteers with registered families to help with the routine labors of care (feeding and bathing the patient) and to provide nursing materials such as diapers and disposable gloves (Ministry of Health 1996; Odek and Oloo 2007). The government actively appealed to the cultural model of the family as the traditional caring unit in Botswana and to narratives of the strength of the Tswana extended family and traditional ethical ideologies (Browning 2008; Livingston 2008). The program recruitment strategy referenced the physical, psychological and material toll of the disease, and contributed to renewed emphasis on the moral responsibilities of citizens to care for each other (Dahl 2009).

CHBC was initially overseen by the Ministry of Health via local District Multi-Sectoral AIDS Committees (DMSACs) (Odek and Oloo 2007). According to the program coordinator in Serowe, funding and oversight of the program was transferred to the Ministry of Local Government in 2012. This integrates the program alongside other forms of social assistance, such as destitute aid and food baskets, which informs my own analysis of these programs linked under the umbrella of bureaucratic care. Unfortunately, during this administrative transition the
CHBC program lost several key elements; including a vehicle allocated specifically to the program as well as clinic-based gardens that provided free vegetables to patients.

Botswana was not the only country to pursue the strategy of home-based care, but it was an early adopter of the model. The home has been a key site for care-giving activities in the wake of the HIV and AIDS epidemic across sub-Saharan Africa. Botswana’s CHBC program is part of an international trend toward home care initiatives, which has been formalized by the WHO. The WHO published a framework in 2002 for governments, donor agencies, NGOs and community organizations looking to establish or scale-up CHBC programs in resource-poor settings. Botswana has been a model and leader in this process. The WHO report and recommendations were developed through case studies of countries with existing programs, including a research team in Botswana. The guidelines also draw from a WHO Study Group report on “Home-based long-term care” (WHO 2000) and an AIDS “home care handbook” (Aids 1993) for health professionals in contact with people with AIDS and their families.

Touted by the WHO, CHBC allows the patient to receive care in a familiar and supportive environment, to reduce medical costs associated with hospitalization, and to raise awareness about the plight of the sick in the community (Odek and Oloo 2007). In Botswana, many patients preferred to be cared for and die at home (Atta and Fidzani 1996). CHBC is a form of government policy that externalizes the cost and task of care to the domestic sphere. Similar policies elsewhere in the world seek to make families the primary managers of care (Hashizume 2000; Falloon 2003). In Botswana, however, this strategy does not represent the government abdicating any responsibility for care. In fact, it represents another point of surveillance between local government offices and citizens. Home-based care volunteers not only help with caring labor; they report on the condition of patients and families to clinic nurses,
ostensibly to strengthen contact between the household and public services like health care. The program also provides a contact point where volunteers could refer families to social workers to assess them for further material support.

**CHBC in Practice**

When the government of Botswana implemented CHBC, policy-makers assumed the presence of a “community” safety net that already existed but simply needed to be mobilized (Ministry of Health 1996). Yet the CHBC program does not reflect a simple maintenance of the status quo in either social or economic life. Volunteers in CHBC participated in novel social roles within patients’ households, entering spaces previously off limits to non-kin to take part in the most private acts of care, including bathing, feeding and touching the sick. By formalizing the presence of non-kin caregivers in the home and extending the reach of women’s unpaid caring labor, CHBC plays an active role in renegotiations about the value of caring labor and what citizens are owed by each other and by their government.

In the early days of the epidemic, the material resources and caring labor of households were stretched beyond normal capacity. “It was very bad. Many people were sick, with ugly wounds. You couldn’t even eat after you saw those wounds,” Mma Bereki, a CHBC volunteer, told me when I asked about the early days of home-based care. Like many of the other volunteers, she was a middle-aged woman already active in her village health committee who signed up when she heard appeals on the radio and at the Kgotla that the country desperately required additional care-givers. The clinic staff registered her as a volunteer and sent her for training in safe handling and care techniques in a neighboring town. After an intensive three-week course, she began to visit families in her kgotla (ward).
Researchers in Southern Africa note that there is a steep gender imbalance in home care programs (Jacques 2015; Kang’ethe 2014). Most volunteer care-givers are women and many men are reluctant to provide such care because of the perceived traditional roles of men as income-earners and women as homemakers and nurturers (Akintola 2008). In a study of CHBC in Kanye village, Kang’ethe (2014) identified that 80 of 82 volunteers (98%) were women and 2 (2%) were men. This imbalance was also in evidence in the Serowe program. Out of the 38 volunteers in CHBC, only one volunteer was male, and he passed away during my fieldwork, so that all active volunteers are currently women.

Volunteers often recounted that they were motivated to volunteer out of a concern for their nation (setshaba). For instance, one volunteer told me, “I did it from a feeling of love to help the nation, especially the sick.” Mma Kabelo explained it to me, “Look, there are no direct rewards for volunteering. We are only doing it for our nation, so that not all of the patients will die.” Volunteers expressed their willingness to fight for the nation, as when Mma Sarona told me, “We wanted to be soldiers against the epidemic, it was killing so many people – the battle was on.” The battle against HIV had touched their lives personally as well. An older volunteer, Mma Peo, applied a similar logic of reciprocity to her participation in this program as the one that applies within household economies of care. She told me, “My grandchild told me I should join home-based care so that when I die people will know me and people will be there for me. that is a message from my grandson who is no longer with. I know that pain of having a child that is sick and passes away. After he passed, I saw that it was true what he said, and that I would help the nation.”

**HIV, Secrecy, and Stigma**
The volunteers, despite their best intentions, ran into complications when they came face-to-face with specific families. Even before the HIV epidemic, illness and chronic disabilities were a private domain associated with immoral actions within the household, and sick individuals were hidden from others outside the family (Livingston 2005). In fact, volunteers uniformly recounted to me that they met with initial resistance from families. Mma Sarona explained to me, “People did not like us at all, the families did not want to accept us into their yards. When they would see us walking by they would close the door. When you knocked, they would not answer.” Mma Peo elaborated, “When I started, we had too many problems, some people did not allow us to see the patients at home. They will hide them, chase us away, and even ask, ‘Who told you that my child is suffering from AIDS?’”

Mma Onametse explained that, “Those families that hid their patients, they thought that we would go talking about the patient's illness around the village. They would just say the patient is sleeping and they don’t want to be disturbed. Even though we were taught that a patient’s sickness is confidential.” In fact, the volunteers were very clear that part of their duty was to protect the patient’s privacy. Mma Reta explained to me that they kept their patient records in special notebooks, “We must keep them safely in there, you can never tell another person – it is confidential. No matter what condition you find when you enter the home, you do not say anything.” Indeed, in the early days of the program, that condition was often quite dire. Mma Reta continued, “Some [patients’] hairs were unkempt, like they did not even have children. Some had lice, we would shave them and bathe them.”

As I outlined in Chapter 3, the practice of care requires an interrelated set of physical and emotional labors that serve to materialize a relational bond. The volunteers had to establish such bonds through the transfer of material resources and labor, which initially required significant
persistence on their part. In sharing one of her hardest cases with me, Mma Reta said she had to return three times to the same yard before the patient’s mother would speak with her:

When I came back the third time, I said this time I am not going to go back home. I am going to sit here until she needs to go and piss and then she’ll have to open the door. I told her that I am not here to play, I have come here to help you however you need. Then she asked me, ‘How did you hear about our situation, who told you that we have a patient here?’ I said I was told by the nurses. That’s when she started talking to me, from there she opened the door just for me to find how unpresentable the child was, then I started helping.

The physical state of a patient signifies the strength of their relations and the fulfilment of kinship obligations by their caregiver. The impoverished conditions and the social stigma of an “unpresentable” patient likely contributed to families’ resistance to visits and their desire to hide the patient away. Mma Reta continued,

I took her [the patient’s] blankets, I put them in water and washed them. It was then that her mother told me she did not want to let us in the house because they didn’t have anything to eat. She showed me the phaleche (maize meal), which was in a plastic bag, and there were worms inside it. She told me that was the only food they had, with nothing else to eat.

That was when Mma Reta started to contribute personally for their food, “I poured out their phaleche and went to my house to get them a fresh bag.”

Others recounted similar stories of personal efforts to contribute to the survival of caregiving households. “At times, there was nothing for them to eat. If they didn’t have food to eat, you would go to your house and get something and cook for them” said Mma Bopelo. In a few cases where the patients did not have proper housing, the volunteers even pitched in to help build shelters. As Mma Sarona put it, “We don’t have much to offer but we can work with our hands. We built a mud house here in Morulamantsi [ward], and for an old man in Makolojwane. We went to gather the thatch ourselves to finish the roof of the house.”
These labors are usually the instantiation of kin relationships and several volunteers made sense of them in such terms. Mma Peo explained, “There were times I had to tell them that I am not only a volunteer, I am also part of the family. I told them, ‘Take me to be one of you, like a sister, father or mother to you. I am with you in the sickness. The patient is my patient.’” Another volunteer put it simply, “You end up being a mother, a sister, whatever the patient needs. You'll wash the patient in the morning, clean the house and see whether there is food there.” The demands of caregiving, compounded by the strain of HIV illness on household resources, created the need for material transfers through these new relations most easily described in terms of kinship. The volunteers established such bonds through the transfer of material resources and labor, which required significant persistence on their part.

**Changing Economies of Care and Distribution**

The initial government intervention into the web of relations surrounding the sick should be understood in the context of the early HIV epidemic. It is also useful to think in terms of economies of care and distributional labor to grapple with how these changes took shape. I use the term “economy” of care because caregiving is a relational resource that circulates within a network of people (Buch 2015). As Julie Livingston (2005, 2012) has argued, economies of care were historically enmeshed within the household in Botswana. They operated from the assumption that the care of a relative generated an obligation for return care and assistance; for instance, the care of children by parents or grandparents entitled those parents to care and support from children later in life.

Despite surface similarities to kin-based care – especially its reliance on women’s caring labor – CHBC represents a complication of this reciprocal pattern and introduces a larger role for various government representatives in caregiving. Caregivers were sent by a government party
(public clinics) and they shared resources with those on whom they could not expect to make their own distributional claims. Nonetheless, the volunteers felt an obligation to address the suffering they witnessed, as Mma Reta explained to me, “I would use my money to buy her [the patient] food because I felt compassion. The nurses were saying that I’m not supposed to be taking the *phaleche* for my children to go and give that child, even though I saw that child was very sick and was the same age as my child.”

This dynamic produces some interesting tensions in volunteer narratives because the volunteers themselves describe daily subsistence as a struggle. Researchers have noted that the implementation of CHBC (especially as a cost-saving technique) obscures the costs that are borne by mainly female unpaid care-givers and the value of their labor in sustaining these programs (Akintola 2008). This tension was evident in the narratives of volunteers. The volunteers currently receive an “allowance” of 300 pula per month (about $30 USD), which has slowly increased over time as more volunteers retire from the program. In 2012 when I began my research, the allowance was only 170 pula ($17) per month. Interestingly, compensation has climbed in recent years, while the number of volunteers dwindled (as volunteers pass way or retire from the program due to old age). The amount of the allowance was an important issue for volunteers because it was a form of distributional income that helped to support their households. As Mma Onametse put it, “I don't have a husband, and my sons are grown so it is difficult for me to get a little something from them. The only thing I have left is the allowance, that is when I will have something to feed myself.” Mma Sarona elaborated, “Some of us considered going somewhere else, because we need a better allowance. We cannot even buy ourselves *phaleche*. We can maybe buy soap and a little electricity and then the money is finished, but we still do not have anything to eat.”
The appeal of volunteers for better financial compensation merged with critiques that the absence of financial support erased their personhood. Mma Sarona explained that they’d ended up in this contradictory position because they’d agreed to work for free initially, “Our allowance is low because we had volunteered as soldiers for our nation, so now it’s a challenge to ask for more, but they are not taking us as human beings.” Another volunteer elaborated, “As volunteers our concerns are because we are human beings, we should be given an allowance so that we can be presentable when we visit our patients.” That their caregiving labor did not lead to a return obligation of adequate support from the government fed into the sense that their personhood and their relational labor was invisible. Mma Reta explained, “They do not encourage us, we don't know why. We even build houses for the sick, we contribute for bricks and thatch. Not even a thank you. Even our president has never come to see what we do as volunteers.”

CHBC is a specific example of how the government of Botswana has facilitated non-kin actors’ entry into the relational networks that underpin care. As they implemented the program, local volunteers re-worked and extended gender-based obligations of care and refigured distributional claims to flow between families, volunteers, and the government. This intervention demonstrates that caregiving labor can be manipulated by bureaucratic care, so that the web of relations that sustains it is increasingly politicized. As discussed in Chapter 4, caring labor is a common strategy which women make claims for their share of distributed resources. Performance of care as gendered labor is thus a key precursor of the volunteers’ articulations of insufficient compensation aimed at government offices. Women’s caring labor ideally exists within interdependent economies of care that generate distributional claims. The CHBC intervention created unresolved tensions that volunteers express in terms of the recognition of their moral agency and personhood. Though the program relied on the language of kinship, it did
not successfully mimic of its networks of obligation, as evoked by Mma Kabelo when told me she would pray “that the government can pay us better because we are his [the president’s] children.”

**Bureaucratic Care in Local Government**

My case study of CHBC volunteers demonstrates the ways in which representatives of the state (specifically institutions like public clinics) have increased their participation within the formerly closed-off domain of domestic caregiving. State intervention has blurred the lines that divide public and private care. The social safety net in Botswana at the village level reflects a similar messiness between ‘private’ citizens and ‘public’ politicians. In this section, I review the ways in which local state representatives are ingrained in the web of relations in village life to establish how these relations have become important for distribution and care.

**History of Local Government**

At Independence in 1966, the first President, Sir Seretse Khama, created Village Development Committees (VDC) at the village level across the country. A VDC chairperson summarized this history for me,

> The VDC program was the agenda of our first president. We took our independence in 1966 then he motivated us to sustain ourselves with our hands. We are supposed to be self-reliant, we make our developments everywhere we can, where there is a committee they are supposed to arrange and make the developments in their areas. That was the biggest role when the VDC started, development through self-help – although these days people are not participating because people like money.

The VDCs are organized by local wards that fall under the Serowe “umbrella” VDC. Residents elect their members of the VDC for two-year terms. Elections are held at the kgotla, and all residents with a valid Omang ID card can vote. Once elected, the members of the VDC are paid on a part-time basis; for instance, they are paid a small stipend for the meetings that they attend, and they also receive compensation as the supervisors of *Ipelegeng* work groups.
The VDCs are an integral part of the village social safety net. Those elected to the VDC become the face of the local government, but they are also a neighbor who has a history of relationships, grudges, and family ties, which shape their work and people’s attitudes toward them. Given that these VDC members were tasked with enabling the caring state by identifying its neediest recipients, they also became entangled in ethical critiques of failed or inadequate care in a similar vein to social workers. For many family caregivers, it was hard to ignore the slight of a local VDC member failing to assist a needy relative, as when Mma Naledi complained to me that her mother had never received a blanket from the local VDC, “The VDC has never come here. Even if others are given blankets around here, the VDC will never come back to register the old lady. If you want to be given the blanket at the kgotla, the VDC have to come here and register the old lady, but they won’t.”

My interlocutors described the VDC members as the eyes (matlo) and ears (dithebe) of the social workers. VDC members lived right in the community and could identify those who were not living well and refer them to the social worker for assistance. The social workers remained the final gatekeepers of welfare programs, but the VDC structure means that residents also play a key role in the social safety net, often for those living right next to them. In this sense, the implementation of Home-Based Care reflects a similar governmental technique of appointing “community members” as representatives of the state at the most local level. Since the early years of independence, the government has attempted to leverage the local networks of kin and neighbors to identify and target specific categories of dependent citizens. Through their local VDC eyes, social workers assess needy cases and assign them to the corresponding category of need (e.g. destitute, orphan, disability), which can be said to compose the social safety net in practice.
The VDC and Social Worker welfare model that emerged post-Independence co-exists with older forms of local government, including the ward “sub-chiefs” or headmen. Historically, these sub-chiefs (kgosana) were patrilineal kin to the paramount chief; they reported to him but oversaw local matters in their wards. At Independence, the democratic government significantly curtailed chiefly authority in matters of land distribution and legislation, yet they have retained their roles as local mediators for conflicts within their areas (Peters 1994). The legacy of the “paternal” model of chiefly authority remains, as several interlocutors referred explicitly to the sub-chiefs in these terms. Mma Tumisang, for instance, described the relationship, “The chiefs are the parent of the households. The community looks up to dikgosi for everything that is going on around the ward.” Indeed, chiefs still preside over matters of household disputes, inheritance, and cattle theft in their customary courts; it is not surprising that they continue to occupy a paternal role in their areas, using their authority to oversee the well-being of families. The legacy of Kgosi chiefly authority also establishes a historical baseline that sets the stage for the role of local political agents in furnishing resources to households in need. The intersecting programs and agents that compose the social safety net in contemporary Botswana serve as a bureaucratic mode of care. As such, we may attend to the relations therein (as did many of my participants) as relations with specific others that at times yield access to care or fail to bring about desired care.

Although I began my ethnographic exploration of the social safety net within CHBC, I quickly observed that families registered in this program were simultaneously subjects of other welfare programs as well. The principle programs that shaped the bureaucratic care transferred to caregiving households were: 1) CHBC, 2) the national old age pension, 3) destitute aid, 4) the “Smart Switch” food basket, and 5) the President’s housing appeal. Across these various
programs, it was government social workers who maintained the position of gatekeepers and adjudicators as to which citizens would qualify for such care.

Virginia Held (2005) argues that the ethics of care is engaged with the evaluation and assessment of care and reflection on the relationships within which it is embedded. This ethical orientation is concerned with the moral value of relations not only within the personal or family sphere, but also in the social and political arrangements in society. The narratives of my interlocutors demonstrate that the ethics of care encompass processes of making such political arrangements “personal,” given that social workers and local politicians are identified as refusing care directly or indirectly through delays of assistance.

The integration of these state agents into local social relations also shapes how their work and responsibilities are enacted. The VDC oversees the *Ipelegeng* work program, which gives them the ability to select which residents will be registered and earn money that month. In my interview with a VDC chairperson in an impoverished area of the village, he informed me that recent laws were going to prevent favoritism in this process, he told me, “Now they have given us the rules of *Ipelegeng* and we have brought some changes into it. All along people were complaining that they were only hiring their friends, but when we started in the office we made sure that people are satisfied so we are transparent.” His story indicates that residents had a clear perception that VDC members could use their position to distribute aid and care to existing relations, although ideally, they should be unbiased in this process.

In this section, I have demonstrated the ways in which the functioning of the local safety net relies on residents to both surveil and report on each other’s well-being to appointed officers. This emerges as somewhat of a re-formulation of deep historical practices in which a local sub-chief would be responsible for observing and addressing material need within his ward. To some
extent, this responsibility persists although it has now been spread out across a network of local actors that also includes social workers, the VDC, and local councilors. Given this local system of surveillance, it is perhaps less surprising that CHBC policy was based on the idea of sending neighbors into homes to help with care. This additional step, however, does firmly blur the lines of the public/private domains of care, which is why this dissertation encompasses such a range of actors in its analysis. As several scholars have noted, we can ask better questions in our ethnographies of care when we move beyond such a binary (Han 2012, Thelen 2015).

**Bureaucratic Care as Disciplinary Technique**

In her work *Life Beside Itself* (2014), Stevenson describes a form of bureaucratic care that is “biopolitical,” because it is concerned with the maintenance of life itself and is directed at populations rather than individuals (3). Although this mode of care maintains physical life, in the Canadian state, it also reveals forms of indifference to the Inuit couched in terms of benevolence and concern (4). Stevenson illuminates the potentially ambiguous role of care in such biopolitics, which links governmental regimes to the daily ethics of life. Biopolitical regimes are based on the adoption of reflexive ethics that Foucault (1988) called “technologies of the self,” which he defined as the knowledge and techniques that individuals use to “effect by their own means… a number of operations on their own bodies, souls, thought, conduct and way of being, to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (18). Colebrook (1998, 27) and Mahmood (2011) have called this process of self-formation “positive ethics,” which constructs ethics as the domain of bodies, selves, and active practices. I raise this concept to illuminate the underlying dimensions of the surveillance and discipline that is the corollary of bureaucratic care. Essentially, the transfers of resources to care for citizens are couched in the understanding that there are right ways to live and comport
oneself, especially as the recipient of aid. In the next section, I elaborate on how bureaucrats describe this comportment in terms of attitudes toward work, money, and intimate relations.

This model of cultivating disciplined subjects through bureaucratic care works in tandem with systems of surveillance embedded in local relational networks. Mma Mowa, a VDC secretary in a relatively affluent ward, uses the analogy of eyes to describe the dual role of the VDC. She explained, “We oversee the projects that the council is doing, because we are their ears and eyes for them. So, our main role is to see around the area what kind of life they are living.” Although she links these tasks as though they were the same, the second aspect is distinct in that it implies using their surveillance to monitor how their neighbors live, whereas the first component requires them to roll out new programs, like Ipelegeng or other initiatives. Rra Bothusi, who works closely with the VDC as a district councilor, also describes an idealistic picture in which the VDC members see and assist all those in need. As he put it, “The chiefs and the VDC, these people are really playing a part, who really see how people are living.” This forms a picture of benevolent surveillance, in which the government is most effective when the people at the local level can keep an eye on each other.

Actual practice, however, sometimes turned out differently. In my ward, the VDC members were not especially visible outside of kgotla meetings (where they sat at the front with the chiefs and councilors). Rumors also circulated about the chair of the VDC at the time, a young man in his 30s, that he was misusing funds to enrich himself and his family. Many family caregivers also shared stories of neglectful VDC members who failed to sign them up for benefits or visit their patient or elder. In many cases people expressed mixed feelings about the VDC, which provides important context for the ideals that bureaucrats expressed to me. Yet the larger point that I make here is the stated importance of mechanisms of surveillance for the
explanation of the social safety net. This is relevant because in the following section I
demonstrate how this watchfulness tends to merge with disciplinary models; so that ‘how people
live’ merges with ‘how people should live.’

This slippage became more obvious as I asked social workers to try and make sense of
their strained relationships with citizens. Mma Tumisang described her encounters with
applicants for aid as a “challenge.” As she explained this challenge, her words shifted to
encompass the uneasy relation between her role as a provider of aid and as a sort of ‘advisor’ to
citizens on their lives. She explained to me,

Dealing with people on a daily basis is very challenging because each and every
person who comes here feels that he or she should be assisted with whatever he or
she needs, but there are procedures and protocol that I have to follow to assist that
person. At times, when you try to advise someone that this is the way you should
lead your life, he or believes that is not the way – the only way is the one that he
or she thinks is right.

I use her description to highlight that encounters between social workers citizens are not solely
about transfers of aid, but also a point at which ideas of how to live come into contact (and
sometimes friction). As social workers attempt to encourage forms of subjectivity and ethics,
they encounter resistance from citizens. The councilor Rra Moeti described a similar dynamic
when he explained the dissatisfaction that people felt with social workers. His description
provides insight into the distinction I am drawing within bureaucratic care between providing aid
(i.e. “hand-outs”) and cultivating forms of discipline (survival skills). His explanation also
positions the criticism as emerging between mismatched expectations:

They [social workers] cannot satisfy everybody because most people, they like
hand-outs. When you think about it though, the social worker may not give that
person free handouts. The social worker can try to help that person by giving her a
skill, survival skills, right? But it’s like most people – that’s where they’ll start
criticizing the social worker that she’s failing because she does not recommend
the free food ration from the government and they would like that ration. But
when you provide survival skills, they do not go in for that.

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Mma Dipuo encountered similar resistance from applicants in her work as a social worker; however, rather than couching the alternative to ‘hand-outs’ in terms of skills, she refers to the quality of “responsibility.” She described how difficult it was to satisfy Batswana who came to her office by saying, “You’ll find that Batswana are used to handouts so that when you give him something they can be responsible for, they don’t want to take responsibility for it.”

These narratives begin to make it clear that the provision of government care also entails the transfer of certain disciplinary ideologies and techniques to help govern the subjects who receive such aid. Mma Tumisang describes this aspect of her work as “teaching” Batswana how to live better. She explained to me,

We also teach them how they can make a change in their life, try to motivate them. When a person is sick, we need to teach them how to change their way of living. The best way is to educate them so that they can sustain themselves to have a better living… We do this through public education, we can also do talk shows to empower people so that they can try to change their lives because we are seeing that people are not developing. We want people to stand up and sustain themselves (go itirela).

In an important sense, therefore, social workers did not purely view their task as distribution to the needy, but to cultivate an attitude of self-sufficiency among citizens that would ostensibly make them less likely to need aid. Another social worker, Mma Dipuo, described the efforts to cultivate this subjectivity, while also indicating the ways in which citizens interrupted these efforts. She told me, “Government is trying hard to teach Batswana and introduce many things that they can use to improve their lives. Batswana do not use the materials that they have been given well, so you’ll find that it doesn’t benefit them. People in need, especially those who are unemployed, the main target of the government is to make sure that those who are serious can improve their lives.” Her narrative demonstrates the expectations that bureaucrats have for aid
recipients, that they be serious (willing to work hard) and responsible (using resources in prescribed ways).

Social workers were also trained to mediate in family disputes, and thus concerned themselves with managing or cultivating proper relations within the home. As Mma Tumisang explained, “Our role is to try to improve the lives of people. We do this by trying to remind those at home in our wards that they should try to live well in harmony with each other.” Mma Pina, a social worker who worked closely with the CHBC program, told me, “One of my main roles now is to visit them at home and do counseling so that they have hope in life. We are not only focused on the sick, but also their family members because it also affects them.” Others, like local councilors, also concerned themselves with the state of household relations. Rra Bothusi described his concern about the state of domestic relations in terms of a break-down in communication, “If we can help people to communicate in their homes, they will know each other, ‘how do I think, how does the other one think,’ so that life can be easy there because they are open to each other. Communication helps to be open to talk about problems… Especially the youth, they don’t communicate, they are individuals who never open up.”

Multiple bureaucrats expressed specific concern over family dynamics surrounding orphans, who they considered to be especially vulnerable to dysfunctional or exploitative family relations. Rra Bothusi expressed a typical view of this when he explained to me, “For orphans we can say that because they are young, they need help from the relatives who sometimes do not take care of them. The relatives will take the food basket and they don’t use it in a proper way, they can take the orphans to the lands and then they will abuse them.” This narrative shows that government officers were not only concerned with the rejection of values like self-sufficiency and responsibility. They also concerned themselves with dysfunctional relations among kin, such
as physical abuse or exploitation of a dependent for the purpose of securing their government resources.

**Conclusion**

This chapter outlined the forms of bureaucratic care that underlies CHBC and the local safety net apparatus, which blurs the line between public and private responsibility for care. In both cases, individual agents affiliated with the state (as employees or elected officials) play an important role within local relational networks. Local residents – elected to the VDC or village council – become part of the safety net through forms of surveillance, as the “eyes and ears” of the social workers. The social workers retain the sole responsibility for acting on these forms of surveillance in the assessment and distribution of aid. As they shared their duties with me, they revealed specific values underlying the provision of aid; such as teaching proper lifestyles, responsibility, work ethic, and independence among citizens. These underlying values and disciplinary logics of bureaucratic care help to clarify and generate the empirical ethics of agents of the state around the limits of care and welfare.

This chapter also establishes another central aspect of this process, which is that – unlike other scholarship on humanitarian care (e.g., Ticktin 2014) – citizens do not uniformly accept these techniques of self and present themselves in corresponding fashion to secure aid. Their interruption of such expectations also contributes to the conflictual ethics surrounding care that I discuss in the next chapter. I now turn to the perspectives of bureaucratic interlocutors as they narrate the rationales and “problems” that they encounter in the practice of bureaucratic care. I develop the lens of conflictual ethics to locate the meaningful distinctions in the ethics of care between family caregivers and those in government roles.
Chapter 6: Conflictual Ethics of Care

Seeking Bureaucratic Care

In the previous chapter, I outlined the description and design of the local safety net from the point of view of the representatives of state agencies, including social workers, district politicians, and development officers. As Biershenk and de Saarden (2014) argue, this description constitutes the “image of the state” that those working within its various administrations seek to project. Before I discuss how the image of their work informs their formulation of empirical ethics, I contrast this image with the story of one impoverished family attempting to procure care from the state in an emergency situation.

Mma Ngwane, at the age of 32, was a single mother living with HIV. She cared for 5 young children – her own and those of her late sister – all under the age of 8 years. When I first met Mma she was living with the children in a makeshift hut plastered over with plastic sheets to cover the gaps and keep out the rain (See Fig. 5). She had stopped taking her treatment because the pills made her feel sick, and she did not consistently have adequate food to take with them. She and the children survived with the aid of a destitute and orphan food basket and her health was too poor for her to work to supplement this. Her boyfriend had been injured in a brutal attack and was not working. Without work, neither of them had access to cash for essentials like water, clothing, or her children’s school fees. The situation was untenable for her and within a few months, she had moved with her children to a neighboring yard. She stayed there with a brother and sister, Boikanyo and Sarona, in their early 20s. They had lost their own mother, who was like a “big sister” to Mma Ngwane so they took her in, helping her and referring to her as their mother (mmarona). When I visited them together in the new yard, I learned that they had in fact lived together on and off since 2012 when their mother passed away.
The siblings had stepped in to help Mma Ngwane after they saw that her elder brother (and their own siblings) had failed to take responsibility (maikarabelo) for her care. The siblings and Mma Ngwane collaborated to get by, sharing her food basket and their intermittent earnings from piece jobs. They were still food insecure, however, and some days they went without food. Mma Ngwane returned to taking her ART when she moved in with Boikanyo and Sarona. She still was not well enough to work and their income was conditional on intermittent work like Sarona booking hair appointments or Boikanyo selling his wood carvings.

The mechanisms of local surveillance (described in Chapter 5) worked in patchy and incomplete ways; for instance, a local VDC member came to the yard to “assess” Mma Ngwane’s children because she saw them running around without shoes. Mma Ngwane took the opportunity to report her other pressing needs, without much success. She mentioned that she needed a proper house – her improvised hut was made of scavenged materials – and asked for
the VDC to put her on the list for the government housing initiative. This did not go anywhere because the title certificate for the yard was not in her name, meaning that she could not qualify for the program. Nor did she ever hear back about her children finally being registered for the “school aid” package (a uniform, shoes, and fee subsidy).

Thus far I have only briefly recounted the routine hurdles and setbacks that characterize chronic poverty for Mma Ngwane and her children. Their contact with various state offices intensified a few months later when a crisis struck. Sarona called my RA and me because they’d lost everything to a fire in their single room hut (the thatch was flammable in the dry season). They had already been through the first bureaucratic hurdle to deal with the situation. Sarona showed me the police report for the fire, it documented that everything inside the house was lost; clothes, school uniforms, food, even the Omang ID card and their SmartSwitch card for food aid. The report stated the “house was burned to ashes.” After obtaining this official report, Mma Ngwane and Sarona went to see their community social worker. She informed them that her only jurisdiction was to replace the school uniforms. After this disappointing news, they walked for an hour to the main district offices to talk to a senior social worker. The social worker did not ask to look at the police report, instead asking them how they planned to build a new house if they were assisted with a tent, which after all could only be temporary. At this point they called us for help.

I called a colleague working the Red Cross in the village to ask for advice. She directed us to seek help from the district commissioner’s office and to say that the NGO had sent them there. We told Sarona that we would meet them at the offices in the main mall; they had to walk almost another hour to reach it. When we explained the case to the women in the office, she told us she was the “acting” commissioner and unable to assist with the case. She suggested that they go see the deputy district commissioner, who was not in the same office complex, but back at the
main district offices where they had sought help from the senior social worker (and been turned away without any suggestion that they visit the deputy’s office). This time, at least, I could pay for our taxi so they did not have to walk an hour back to those offices.

After we took their case and police report to the deputy commissioner, he told them that someone from the office would come to their yard to assess the situation. We parted ways at this point. They walked back home, but the officer drove to their yard and arrived before they returned and was unable to do the assessment without someone present. The situation had to be postponed yet again. Sarona called back to say they would try again the next day, but would make sure that someone would stay home in the yard to be there for the visit. A few days later my colleague at the Red Cross informed me that the commissioner’s office had finally provided them with a tent. The commissioner could only help with an emergency shelter, and she was counselling them on how to get the social worker to deal with the other lost items. I left the village a few months later so I never found out whether everything was replaced. I did hear later that Sarona had secured a job at a local hair salon and would be making more regular money.

The story of Mma Ngwane and the siblings speaks to the grinding reality of poverty and the layered responses of Batswana to care for each other and mitigate the worst of it. We see this in the way that fluid residence patterns provide a partial coping mechanism, as when Mma Ngwane moved in with Sarona and her brother. Even with such relational strategies in place, poverty heightens the reality of precarity. One fire, lit accidentally by a child inside a small and crowded hut, becomes a full-blown crisis. I recount this story in detail as a preface to the following chapter to counterbalance the narratives of entitlement and laziness that social workers deploy. There is nothing “lazy” about walking for hours from one office to another; sent back and forth with only partial information. I argue that it shows that personal “initiative” will only
take you so far; after all, they had done their diligence in filing a police report and going to the social worker. This initiative will always be met with the specific attitudes and biases of the social worker; in this case, the social worker used the broader issue to poverty (how will you build yourself a new house anyway?) to undermine the provision of immediate aid.

**Conflictual Ethics and the Limits of Care**

The state is not a monolithic entity; rather, it is a series of overlapping projects and processes, as such it is always under construction and a site of “competing normative ideas” (Bierschenk and Sardan 2014, 6). Citizens, like Mma Mgwane and her niece, navigate multiple locations, offices, and officials in their attempts to seek aid. The above narrative suggests that the existence and “image” of the public safety net in Botswana does not entirely overlap with the reality of practice, and in this friction, emerges the paradox of bureaucratic care – both present and absent at once. I develop the concept of *conflictual ethics* to trace the divergent framings of citizens and bureaucrats respectively about breached social expectations of care. This allows me to better understand how concepts of care emerge in the contested ethical field that encompasses significant tensions around dependency, governmentality, and subsistence.

In the remainder of this chapter, my goal is to elaborate on the empirical ethics that state agents employ to make sense of failures of care within these institutions. In analyzing their narratives, it became clear that my approach must make room explicitly for divergences and conflicts within the ethical framings at work. To address this, I advance a theoretical framework that I call *conflictual ethics*, which specifically focuses on the debates and tensions that emerge in these post-hoc accounts between differently positioned individuals. Bureaucrats employed an interpretive frame that made sense of bureaucratic care within disciplinary techniques to produce specific political subjects (see Chapter 5). When citizens challenged or complicated this project, bureaucrats responded by criticizing dependency and irresponsibility in the “mindset” of citizens.
This lens reveals significant tensions between welfare practice and policy, and I argue that it contributes to a gap between theories of dependency and realities of interdependency. The case of Botswana heightens this tension due to the specific socio-historical juxtaposition of a paternalist state, a developmental ethos, and a setting of economic precarity that has expanded the practice of distributive strategies beyond restricted “marginalized” groups.

**Bureaucratic Ethics of Care**

Even in cases where government agents do not enter into the household to offer “hands-on” caring labor, local social workers and development committees are key gatekeepers to the resources that make care possible. Their material aid, if not their physical labor, is a key part of household caregiving arrangements, making them common targets of caregiver critiques of failed or inadequate care. Though leaders (including chiefs) have long concerned themselves with the basic quality of life of citizens, the role of the state in care-giving (especially for the sick, disabled, and orphaned) has intensified in the past three decades. Leira (1994) uses the concept of the “caring state” to denote the welfare state that employs a mode of bureaucratic ethics to provide care for its dependent citizens. I apply this lens to statecraft in Botswana and its intervention into household caring relations serves as the foundation of the conflictual ethics of care that emerge.

**Development as Value and Practice**

Citizens laid significant blame on bureaucrats for the failure to furnish resources and thus to impede caregiving (and in some cases as in the opening vignette this is not without some merit), which led me to pursue meeting and speaking with these agents to allow them to define the problem in their own terms. I provide space for these bureaucrats to make sense of the limitations of care and the accusations that they face personally for its failure as they engage one on one with citizens to assess and adjudicate claims. My analysis reveals a set of values and
rationales that at times mirrors citizen narratives, but also shows significant divergence in their understanding of the problem of care.

Certain concepts appear to organize the work of bureaucrats and to help them unpack their own role in society; for instance, the concept of “development” plays a pivotal role in their narratives. They describe development as a set of practices and concrete projects, but it also offers a value orientation and interpretive grid for their observations and interactions with citizens (Ferguson 1990). Renste, a young man recently elected VDC chairperson of a large impoverished ward, emphasized the practical nature of development as specific “projects” that he oversaw in his ward. He explained to me, “The main role that I’ve been given by the MP (member of parliament) in local government is to see that whatever developments are done in L—1 [ward], have to pass through me. I will go around telling the public that the government wants to do such and such development in the area.” Lobone, the chairman of a neighboring VDC, echoed these ideas and emphasized the role of VDC members in designing development projects with residents. He said, “Our responsibility is to see that as VDC, there are developments in our area and through consultation with the public. We meet with them, we ask them what they need of in their area for developments, and from there we take the matter to the councilor as the VDC.” In these narratives, development comes across as a generic social good, in reality it could encompass a range of processes. For example, in Lobone’s ward, he was working on specific initiative to install benches for the elderly at the community office. This would allow them to sit and rest when they gathered to collect their monthly pensions. He was also trying to raise funds for better office equipment and a computer for the VDC (the office was in a small converted house and was admittedly sparse.) Development could also entail working on measure to improve the transparence of Ipelegeng work projects. In other wards that I visited,
planned developments ranged from fixing up old kgotlas or re-roofing community halls, installing electricity in the ward, all the way up to a more ambitious proposal to clean and restore a local creek bed for potential tourist revenue. The pace of such projects was excruciatingly slow. A proposed road extension on the north of the village was meant to start in 2015, and yet to begin when I visited in 2017.

In general, this form of local development focuses on the provision of infrastructure and public resources. This is intimately connected to the value of development as a force that improves the lives of those it reaches, or as Rentse put it, “how people are living and if their lives are changing in the area.” The local meaning of development links the more universal goal of improving living standard with the Tswana value of dignity and social integration as I describe in Chapter 3, which Rentse touches on in the following statement, “We are supposed to look at how the people are living and if it’s an appropriate lifestyle.” His implication, of course, is that bringing everyone into an appropriate lifestyle and standard is a matter of the right public works.

Development also comes to signify the value of the responsive state, which builds on the analogy of sight and surveillance that I described in Chapter 5. In the words of Mma Mowa, the secretary of a VDC in a wealthier area of the village, development takes on an explicit link with “care” in the VDC’s mandate: “My main role is to help the chairperson of M-- VDC to take care of all the people Kg--- ward (re be re thokometse bothe).” Specifically, this care breaks down into surveillance of key categories of need, as Mma Mowa explains, “We look at those living with disability, those who don’t have enough in their lives, and how people live in the village.” This responsiveness ties the logic of bureaucratic care to the value to the development state, watching over its citizens and giving them new development projects. It is an elegant discursive
package, yet it clearly exists in tension with the experience of “recipients” of this care, who regularly sought help or care but were denied it or delayed in some capacity.

**Proximity as Value and Practice**

Bureaucrats often emphasized their proximity to citizens, which emerged as another key value of their development practice. Interlocutors preferred to position themselves as “intermediaries” of the state. This distanced them from their political offices and positioned them closer to the people they served and it reflects the blurring of public and private as a meaningful distinction (see Chapter 5). This identification with “the people” is evident in the way that Rentse describes his role in local development planning, “We as the public, will normally talk about what we need. From there we will call our committee to come together to make a proposal and take it to where it has to go.”

At the district level, elected representatives (councilors), employed a similar discourse to describe their roles as “intermediaries” between local communities and the government. Councilor Rra Ditimo described his role to me as, “I am a councilor. It’s a mediator between—it’s a link between members of the public and government. Really, the idea is that as a councilor, you engage with members of the community. You see their needs and you take that to government.” He explained that there was a procedure to follow in this process, “You have to talk to the people and they give you ideas, they come up with the programs they think can be done, and then you go to council and you present that to council, that’s how you do it. After council meets, you go back and then you report what you have achieved.”

This meant that district councilors should be easily accessible to residents. Modisa, a young councilor in his first term, elaborated on this for me,

> I do not have a job description. I work one on one with the electorate. Our democratic republic formed long ago, using the *kgotla* system as the platform for
interacting with the public, so that is what we do. We arrange kgotla meetings within the ward and the village. We also pay visits house-to-house, and meet them there. As councilors, we are the first representatives of the people from the ground. They usually come over here in our homes with their issues, we take them to the relevant departments.

This is a very “personalized” model of local government, one in which Modisa jokingly recounted a councilor might invest a great deal of personal resources: “A lot of people need assistance in one way or another, there is never enough to help people. You need to be very strong financially to work with the people. If you look back, you’ll find that retired politicians or councilors, they’re not so wealthy. We use most of our time concentrating on the needs of our people, use most of our resources with them.” In the idealized picture, these politicians represented a node of resource distribution and bureaucratic care, and the reality could be somewhere in between. While most of the councilors whom I met were not especially “hands on,” Modisa was quite active in his region. When I returned in 2017, he was driving a large van with “Koloi ya Bagodi” painted on the side (car for the elders), which had been donated by the area’s member of parliament as a resource for citizens. Modisa gave out his personal number and people called him when they needed transformation at any hour, often to the hospital. He also used the car to transport the youth football league to their tournaments and women to funerals outside of the village.

**Work as Value and Practice**

The role and duties of state officers were also shaped by logics that were less explicit than providing public works and shuttling the elderly to where they needed to go. I begin to examine these unspoken values by looking at the design of aid programs. On the one hand, there is the direct transfer of resources; both pension money (for disabilities or the elderly) and food rations. On the other hand, are the suite of recent “poverty eradication” programs that provide
small start-up capital and materials for Batswana to begin micro-enterprises, such as rearing chickens or tent-rental businesses. President Khama expanded this second class of aid around 2012, with a “backyard garden” project that provided nets and seeds for approved citizens to grow food in their yard. That project met with limited success as it did not address on-going costs like water, or other issues like fencing that keeps animals from decimating the gardens. Despite that setback, the initiative grew to encompass other forms of small business to help Batswana generate their own work and income.

Arguably the poverty alleviation measures have expanded the government’s provision of aid, but only under the rubric of personal responsibility and market logic that frames the poor as potential small-business owners who can lift themselves out of poverty through their acumen and initiative. This policy formulation also ties back into the logic of bureaucratic care as a disciplinary regime – in which the success or failure to alleviate poverty comes down to the attitudes and behaviors of citizens, rather than to policy or funding structures. It also further retrenches the category of legitimate dependency only to those who are physically unable to work (the sick, elderly, and impaired), seemingly to disqualify those who are poor but able to work from government care.

This intervention reflects specific values, not all of which are western impositions. For example, the concept of itirela, which means to do something for oneself, was highly valued among Batswana. Mma Tumisang reflected on the shortcomings of direct transfers of aid in terms of the values of itirela, pride, and social status. She was discussing the needs of people with disabilities when she told me, “They can’t do anything for themselves. Maybe the government could do something, give them better ways to make their living other than handouts – because most of the time, handouts do not help people. A person feels proud when he does
something by himself. Someone doesn’t feel proud when they are only the recipient.” In her formulation pride derives from work and from independence as opposed to charity.

Interlocutors also imply that certain forms of work are more legitimate than others. As I discussed in Chapter 4, distributive or improvisational livelihoods were common. In this sense, many of the Batswana that I knew were already entrepreneurs – working as hair dressers or plumbers or selling airtime – just without the capital and security of a registered business. The poverty programs seem to obscure this resourcefulness, and multiple social workers and VDC members described this to me as an irresponsible strategy for getting “fast money,” rather than the long-term discipline of building a business. Rra Moeti described this type of work to me as the opposite of itirela, because it trapped people in a cycle of seeking work from neighbors and others. He explained,

Batswana are lazy, they just want to be spoon fed without helping themselves (ba sa itirele). When I come home they say, “Councilor, give me a job to clean your house.” They want to receive help without them doing anything. Come and clean my house and get the 10 pula so that you can afford to buy bread. But tomorrow you know he must go to another person so that he can help them again. They want to receive without doing anything.

Curiously, what drops out of his narrative entirely is the fact that these individuals are “doing” something, they are cleaning his house in exchange for pay, although 10 pula is only about $1 USD. He describes hiring them as an act of charity rather than a market exchange. There are indeed social values at play; his judgement stems more from their position of poverty than it does from whether they are working. If the same individual started a maid service, doing the same work with the legitimacy of a business license, they would be judged entirely differently. Certain forms of work are legitimate, while others (especially improvisational means) are de-valued. It is important to clarify this point now because in the next section we will
see how many bureaucrats disapprove of other distributional strategies, including government aid.

In this section, I have demonstrated that bureaucrats represent their work in the context of certain key values, which are associated with corollary practices. They spoke of development projects and linked this closely to the surveillance and responsiveness to the way of life of their constituents. They positioned themselves as close to citizens, representing their interests to the state. They are much like Osbourne’s (1994) ethical class of bureaucrats who frame their work in terms of the good of public service. There were also, however, more implicit values that shaped encouraged specific forms of work and economic outlooks, favoring formal business ownership above improvisational piecemeal labor. Both the explicit and implicit values and goals of bureaucratic practice offer important context for the next section, in which my interlocutors offer their empirical justifications for why bureaucratic care fails.

**Social Welfare and the Limits of Care**

Given the importance of personal discipline among recipients of aid, it is not surprising that bureaucrats gave rationales for the limitations of aid based on the failings of citizens. I use the frame of *conflictual ethics* to highlight the debates and tensions that emerge in post-hoc accounts between differently-positioned individuals. Conflictual ethics offers a distinct approach in that it seeks specifically to examine how the emergence of ethics surrounding care happens within a field of debate and dialogue rather than as a straightforward realization of shared values. Within this frame, I focus on how bureaucrats framed the problem of care in terms of instilling a set of ethical values such as self-sufficiency, responsibility, and work ethic.

The Serowe Administrative Authority (SAA) employed social workers in community development offices throughout the village as the frontline agents who assess and respond to the needs of village wards. Modisa described this system in spatial terms, “That [welfare] officer is...
the person at the center. She’s the person who does the assessment of these people. If the old man is sick and is eligible for the pension, the social worker will be here to assess that. We’re basing it on their assessment whether the person can qualify for programs.” Rra Bothusi, a district councilor, outlined how the safety net functions around the recommendations of social workers. “The social worker is the key person, assisted by the VDC. The VDC are from the villages, the wards. We all recommend to her. She will decide after she does the assessment.”

Although there was a network of people who surveilled and identified possible recipients in the community, all claims were funneled to the social worker and she alone had final say on the deservingness of the claims. I pay special attention, therefore, to the empirical ethics that emerge from social workers as they explain the limitations of their work.

I spoke to Mma Sabina, a social welfare officer employed at a local community office, about her job, which she described as the “provision of social welfare services to those who are needy and to vulnerable groups.” Her definition of vulnerable groups focuses on those with authorized dependency on the state, such as “destitute persons, registered orphans, children in need of care – those abandoned by their parents, needy students. Sometimes we deal with the elderly assisted under the program of destitution.” In a separate category were the citizens who were physically able to work and who just needed the poverty alleviation or empowerment programs that I mentioned in the last section. She explained, “We also help those who are unemployed, they are assisted with empowerment groups so that the chances of them being destitute in the long run is lower.”

Mma Sabina, who had been working as a social worker since 2009, had been moved around to various community offices during her career. She speculated that the biggest challenge in her work was that the “demand” was just too high. Interestingly, Mma Sabina framed this
demand in terms closer to a “pathology of poverty” model (Greenbaum 2015) rather than a broader structural assessment of the high rate of unemployment in the country. Mma Sabina felt that the problem with the contemporary welfare system was that too many Batswana needed it, which related back to the failure of families to live up to their responsibilities. Mma Sabina explained that, “The demand [for services] has gone up. Like I said, the social structure or the family structure is deteriorating in some way. Family members are no longer supportive of each other. They lead individualistic lives, so if anyone is needy within the family he will have to figure out himself how to survive.” She engaged in similar critical claims about absence of care within relational networks that family caregivers pointed out in Chapter 4. Mma Sabina speculated that the dependence on government resources was reducing their desire to use their “own means” to care for others:

I do not know why these days the immediate family members do not care much about their needy relatives. Is it because of the programs the government has introduced? In the beginning, there were no programs like orphan care or destitution, home based care, so people used to take care of their own with their own means. But since the introduction of these programs, people have changed, now they want everything from the government.

Mma Sabina was not alone in this concern. Mma Dipuo (a social worker for another ward) also felt that the balance of responsibility for care was shifting between kin and the government, and dependency on aid allowed families to shirk their duties. As she explained, “The programs for destitution and orphans, they were not there before. Before them many people (batho ba bantsi) were still helping each other. The relatives were helping those orphans, but now the programs have started and they feel it’s the government’s problem.”

According to these social workers, welfare programs were breeding disregard amongst kin. Yet others positioned the role of the government as a response to neglect or absence of family care. For instance, Mma Pina described the need for home-based care as follows, “HBC
was started because they were seeing that the family members were not doing anything to care for their patients. Especially when the patient was sick – they’ll go backwards or be in denial saying the patient should take care of themselves. They won’t even be following our Setswana culture that we should be caring of each other.” Mma Tumisang spoke about a related anxiety for the plight of orphans, which required intervention. She said, “You’ll find most they are not well cared for by those left at home with them. You’ll find that the orphans are underage and the caregivers will just do anything to take advantage of the food basket.” This supports existing ethnographic findings that orphanhood and government programs have provoked increased anxiety about kin-based care in Botswana (Dahl 2009, 2016).

Modisa, a district counsellor, elaborated on the role of the government to get involved in these cases of neglect. He told me,

When you start neglecting your responsibilities, that is where the government now comes in, because we have realized that there are people who are not well cared for. Then we can come in here and provide some of the necessities that other people do not provide. I may have the responsibility but I do not have the necessary resources to take care of that person. I don’t have the money, I don’t have anything, I’m not working. That is why I’m saying the programs of the government come in handy for caregivers, because if that person now has monthly 300 pula, monthly food, then if I’m responsible enough I know I’ll be cooking, and maybe we’ll share the food. But regarding the money, that should only be used for what he needs most.

In Modisa’s model, the government provides resources for the family to fulfil their roles and even acknowledges that they may share the food. This was acceptable if the family did not take too much advantage of the other resources, including the appropriation or misuse of their money. The duty of the government to provide caring resources also entailed a discipline on the part of citizens to act in certain ways with such resources. This ethical (and disciplinary) logic set the parameters of the “effectiveness” of aid and the parameters by which officers could blame specific behaviors or attitudes that disrupted the effectiveness of the programs. Mma Sabina
described such behaviors as exploitation, “People now want everything from the government. Even to an extent of exploiting the programs. If they have someone who is disabled, even if they have the means, they will exploit the program because they see that individual as an advantage to be able to get it.” This exploitation involves taking advantage of the dependent person – who is taken in not out of love but out of greed, as well as the government office that is now paying for care when it should not.

Beyond being concerned about families with money taking advantage of government aid, social workers also wanted recipients to use aid properly, for its intended use rather than to generate cash. Mma Dipuo gave the example of the Basarwa (ethnic minority) community in the village, who abused government aid by selling their food basket rations for money. Mma Dipuo informed me, “These ones [Basarwa] when they get on Home-based care or destitute package, they can go and sell it and drink beer. Even for the programs for children, the orphans and student program, still they would sell it.” Not only did this type of behavior manipulate government programs, it also harmed the needy individuals that they were supposed to care for. Mma Sabina, who had already expressed a wariness of exploitative relatives, explained that her role was to step in to protect the dependents who truly needed the aid. She told me, “You’ll find that those who are not able to provide for themselves and depend on other relatives suffer the most, if they don’t have their own source of income. Now people prioritize their own needs over those of the ones who depend on them, so it’s very important that we provide them with something.” These narratives express concern that government transfers are not reaching those who are legitimately dependent because manipulative relatives appropriate the funds for their own purposes. Government officers do not want to see programs become a source of easy money for some, while those in legitimate need remain neglected.
Government officers made similar claims about the misuse of money impeding the success of their other programs. For poverty alleviation programs, both social workers and councilors claimed that most beneficiaries could not properly manage the money. Rra Bothusi gave an example, “Young people don’t want to group themselves for a cluster [cooperative]. They want individual funding yet they don’t use the money properly – they just buy the cell phones – and the projects collapse as a result.” These types of programs are important because interlocutors consistently juxtaposed them as superior to “hand-outs” or simple transfers, like food baskets. He went on to explain that the destitute were those who “you can direct them, you can show them skills to sustain themselves,” thus they are lower on the hierarchy of need than either the elderly or those with disability because “they cannot sustain themselves for tomorrow” even with the desire to do so. They key is to provide resources to the legitimate dependents first, and then to teach the right skills to the poor (destitute) so they can pull themselves up.

Social workers felt their role was to cultivate self-sufficiency and they saw dependency (outside of the previously mentioned categories) as a problematic attitude and behavior among citizens that emerged from a lack of responsibility. Mma Sabina explained, “We say it is like the community nowadays doesn’t want to take responsibility for these problems that are in society, they want everything to be given out by the government. They are not willing to take part, even those who could have made it – doing certain things for themselves, they want to rely on government welfare programs.” Government officers were in danger of cultivating or contributing to such entitlement if they were not careful. They were more interested in poverty programs because they instilled the skills and discipline to generate income through a personal business. They tended to blame the relatively low impact of such programs on the attitudes of Batswana. Mma Sabina, for instance, believed that people’s disinterest in “self-help” programs
was due to a preference for “fast” money (this echoes Rra Moeti’s earlier claim). People prefer to be paid immediately rather than to plan long-term for self-sufficiency. She explained,

Batswana are still not yet ready for entrepreneurship; I don’t know if it’s the attitudes or the mindset. They want to get jobs that they can do and get paid, that’s the problem I find. Others who could benefit from the project, in the long run abandon the projects and go to find paying jobs rather than staying and earning for themselves. Their mindset is still the problem… Their problem is because they want quick money. If they have to go rear some livestock, which will take years, they can’t wait. They do not opt for the programs or just abandon them. If it’s two or 3 months without income, the person feels leaves the project and goes to do something that will pay right away.

Kabo, a VDC chairman, shared this concern although he was more specific that it was an issue with the youth, “The youth of today like cash too much, you find they flock to Ipelegeng but that’s something temporary.” Rather than focus on what “two or three months without income” might mean for survival (how will they eat? How will they pay for water or transportation or school fees?), bureaucrats attributed this connection between work and fast money to an attitude of irresponsibility. The government simply offered the programs; bureaucrats placed the responsibility for their success on the shoulders of the citizens who chose to pursue them and worked hard at them. Thus, when the projects failed, it was easy to accuse Batswana of laziness or faulty work ethic. A VDC secretary reflected on this, “I believe that all of us are helped, and those who are not getting help I will say is those who are lazy.” The self-help incentive model of poverty eradication comes couched in terms of empowerment, but clearly feeds logics of blaming the poor for their failure to improve their lives.

Modisa built upon this theme of laziness as he told me, “Various reports indicated that we are a lazy nation. Truly speaking, that is what we’re doing. We have this sense of entitlement as Batswana because the government is doing too much for us as citizens.” Mma Tumsang echoed this sentiment that laziness was a type of mentality or outlook that prevented people from using
the self-help projects. She explained, “The biggest challenge is the kind of mentality people have toward each other, because people are very lazy. That person is too lazy even to apply for anything because they’ll want to do other things. Like for instance, the youth don’t want to make application to the Youth Development Fund (loans for young entrepreneurs) because they feel it is too much paperwork.” This type of attitude provoked a disciplinary response among bureaucrats, who felt it was their role to help educate or motive Batswana to change their ways.

Mma Tsholo an officer at the Red Cross called it a “feed-me” mentality, a way of living based on passively waiting for resources and services to be delivered to you. As she put it,

Our community has developed this “feed-me” thing. You know what, they just sit there and wait to be given everything… They are in a relaxed mode about their lives. Around this area, they do not want to graduate from this life they are in, they want to be there because government things [resources] are coming. Once they graduate from that they are no longer considered vulnerable and so they will miss out.

She describes the specter of dependency that lurks within the welfare system, threatening to provide the incentive or promise of future hand-outs so that people to stay in their current situation, rather than “graduate” to more self-sufficient lives. In the next section I address how the logics of self-sufficiency guide the implementation of programs in such a way as to “minimize” this threat of dependency.

Itirela, Disability, and Destitution

Dependency haunts welfare policy and practice; it seems to contravene the foundational values of autonomy and independence at the heart of modern market-based economies (Ferguson 2015; Reindal 1999). Scholars have critiqued autonomous personhood from the point of view of hegemonic “western” values, but I want to complicate this picture rather than replicate the non-western “communal other” becoming individualized. There are also Tswana ethical values intermingling with development ethos at play in the ethics of dependency. Bureaucrats referred
to the Tswana value of *itirela* or self-sufficiency in their critiques, which helped to mark the boundary of legitimate need. As I mentioned, there were two categories of aid, either “handouts” or “self-help” programs. *Itirela*, the ability to work, determined who could receive which type of aid. Social workers also used this to frame their work; they not only administered aid, they also helped Batswana (who were “able”) to work and live in the right way through self-help. The social workers referred to the policy on destitute persons as their guide through this process.

The national policy on destitute persons was revised in 2002 by the Ministry of Local Government. Section 6 defines these a destitute person as “An individual who, due to disabilities or chronic health condition, is *unable to engage in sustainable economic activities* and has insufficient assets and income sources.” Insufficient assets and income are defined as fewer than 4 head of cattle and less than 150 pula ($15 USD) monthly income. The “inability to engage in economic activity” can relate to old age, mental or physical disability, emotional or psychological disability, terminal illness, or a child under the age of 18 (Botswana 2002). In addition, the policy specifies there is a difference between permanent and temporary destitution. In the case of permanent destitution, the individual must of be an age, physical or mental condition, that “renders them completely dependent” on outside resources (*ibid*, 7). In the case of temporary destitution, they are only incapacitated for a limited period before they can return to supporting themselves. This is targeted at working-age adults to provide them with the “skills, knowledge, and right attitude” to engage in economic activities and obtaining a livelihood independent from the state (*ibid*).

While I was in the field, the Office of the President was in the process of introducing a monthly pension for those living with disability. The pension would provide 300 pula per month for the additional costs that families faced in caring for such a dependent. At the time, social
workers and nurses were going out in teams to conduct field assessments of beneficiaries. Disability, much like permanent destitution, required a total inability to help oneself as the primary feature for receiving government care. This meant that the new pension would be restricted only to those with the most severe disabilities. Those who were less severely impaired should be assisted with self-help strategies just like other Batswana. A VDC chairman told me, “Even among those living with disabilities, I feel that there are those that can work, you can hire them in Ipelegeng and they will accept. But some you’ll find they cannot work so they are the ones that need help.” Many of the other officers echoed this sentiment; describing those with disabilities as those who “cannot do anything,” are bed-ridden, are not active, etc. This framing tended to assume a clear distinction between disability and ability.

Of course, this distinction was murky in practice, and caregivers of those with both mild or severe disabilities sought out the additional assistance of the grant. Moreover, the ‘alternatives’ of economic empowerment were simply not forthcoming. Modisa reflected on the distinction, “Disability is not inability, anyway. Some other disabled people get other government programs because they can do something for themselves. But we’ve been getting a lot of complaints, that the grant program is new and people didn’t understand who benefits from that program, who will be approved. The program is only aimed at those who cannot do anything for themselves. Those that are not capable.” Modisa emphasized that the purpose of on-site visits was to visually assess who was “capable” or incapable of working.

Mma Dipuo, a social worker, described the destitution policy guidelines that she used in her work; they reflect a similar logic to the restrictive notions of disability. She explained,

The potential destitute are those likely to become destitute if not assisted. Those ones we normally assist with empowerment programs so that they don’t go to the level of permanent destitution. Within the category of permanent destitution are the individuals who absolutely do not have any resources to make a meaningful
living, those who have physical or health circumstances that render them unable to work or engage in anything that can help them come out of that level of destitution. The primary factors that we look are if somebody has the resources, and the physical ability of an individual.

She describes how the policy is put into practice to distinguish true dependency from the need for self-help. Although all the social workers told me that they used this policy as their guide, they continuously had to use their personal judgement to apply these rules. Mma Dipuo did not highlight this element, but other interlocutors were very specific that the assessment had to include the larger household as well as the individual. Mma Pina described this process to me, “We look at the environment and assess by looking at the families to decide if this family has a lot of poverty. We also look at SES, and how many of them are working. Even if they are working is the support consistent or inconsistent.” When she determined need, she had to account for the role that person had played within the family – was that person a bread-winner? Were there still others working or income streams that could pay for the costs of care?

Rentse, who helped refer people through the VDC, also narrated a similar approach. He said, “We look at those who are able to sustain themselves and those who cannot, and we’ll register them under destitute. There is another old man, who cannot do anything for himself, but he has children so he is not registered.” This explanation assumes, of course, that those children will provide for the old man. In other cases, Rentse noted that the families are very large and there is “not even a single breadwinner in the family.” He described that “what counts more is the status of the family.” The role of caring labor from kin, and the relational nexus of care, continued to play a key role in these assessments, perhaps even beyond individual autonomy. Most bureaucrats framed their duty as a second line of assistance, after family relations. Mma Tumisang described the importance of harmonious relations surrounding a person:
We are primarily dealing with needy groups, so I’ll say that proper caregiving means giving those people social support, though they also need material support. First, their immediate family members can come to us. We need to establish if there are any among the family members who can take care of those people, emotionally, socially, materially. Because the individual needs all those things to be able live happily… So it’s not only the material status that we are looking for, it’s also the emotional and supportive factors. Sometimes they lack that, even if they have parents, so they need help.

These narratives reveal an interesting tension between an abstract principle (the model of individual destitution) and the evaluation of a lived reality of relational interdependence. The social workers are empowered as gatekeepers to make the final decision, but this includes many factors: Is this family rich enough to support this person? Can the children do their duty? Will they use the aid well? Perhaps unsurprisingly, this decision commonly generated conflict between citizens and social workers. Many families complained to me that they were denied resources that they badly needed because of bad decisions of social workers. For instance, I heard repeatedly from caregivers that they were denied aid because they had a large house, even though securing food remained a struggle. Others had been denied aid because they had children who were working, yet they complained to me that they could not control when or how much these children provided and they remained food insecure.

The gap between what citizens need in practice and what procedures dictate in policy created a space of tension where conflicts between bureaucrats and citizens could emerge. According to bureaucratic interlocutors, the need to restrict material aid arose in several cases: 1) if a family was overly dependent on government programs, 2) if they could help themselves but chose not to for material gain, or 3) households were not using resources properly to support their dependent. The concern about these trends did not merely affect the individual judgements of social workers, it also shaped welfare policies. For instance, the aid package for orphan care was scaled back after it was introduced. Mma Sabina described the situation, “We used to give
500 pula to each orphan [as a food stipend], supposing you have 10 orphans in one household, that is 5000 per month. People used to misuse the food. So now we only give 500 pula for the first child, the others will get 250 each.” This policy deliberately reduced the distribution of resources in the face of unruly or irresponsible practices among households.

Ethics of Authorized Dependency and Labor

The narratives of bureaucrats demonstrate that welfare programs emerge from notions of government responsibility, which some interlocutors described in terms of their obligation to care for citizens. Yet bureaucrats also identified many problematic attitudes and behaviors among citizens that subverted the rightful distribution of aid; citizens were entitled and lazy, even exploiting and using resources for their own needs. The contradiction at the heart of this tension is more legible if we consider the distributive labor and flows that characterize life in Southern Africa. Distributive strategies based on interdependency and the exchange of care for a share of resources were ubiquitous among my participants. Yet government agents did not recognize this as a legitimate strategy and sought to implement bureaucratic care based on an outdated binary of productive labor versus authorized dependency. This is evident within the structure of social programs; direct transfers are only designed for a restricted segment of physically dependent persons, while all other individuals are subject to economic and entrepreneurial logics of “self-help.” This relates to the fear that aid for the physically able will produce dependency where there was none before.

Ferguson (2015) suggests that the “bogeyman” of handouts and dependency originates in mainstream development practice, in which the problem of poverty is one that must be addressed by bringing more people into “productive labor” (36). In this model, if one simply gives money to the poor – to all those who ask for it – they would misuse or waste it and lose any initiative to work. These concerns are clearly present in the explanations of my interlocutors. Yet this
assumption obscures several key processes; first, that wage laborers are just as “dependent” on others except they depend on wages rather than ‘aid’, and second, it erases the role of non-waged labor (such as caring labor) as valuable and deserving of distributive compensation (ibid).

What are we to make of such divergent evaluations of the work of dependency between citizens and bureaucrats around the issues of care and basic needs? It is necessary to recognize that not all dependency is equal. There exists “authorized” dependency (which can be read as the inversion of the historical able-bodied wage earner) that includes the elderly, sick, disabled, children and reproductive women (Ferguson 2015, 40). These persons are the subjects of legitimate government provisioning, which has been codified in the official Destitute Policy (Botswana 2002). This model no longer fits a world, however, in which many able-bodied men (and women) can no longer access the jobs that provide the economic independence expected of them. Nor does it recognize the inherent interdependency of household subsistence, which requires the circulation of care and other resources – both wages and otherwise – between multiple bodies of various abilities to secure subsistence and wellbeing.

I propose that the conflicting ethical perspectives among my interlocutors emerge from this central tension and misrecognition about care, survival, and interdependence. Family caregivers, even those who fall outside the bounds of “authorized” dependency, recognize that claiming dependent status to access state resources is key to their survival. Bureaucrats, however, continue to employ a model that restricts dependency and panics at the thought that their programs contribute to it and undermine the Tswana value of itirela or self-sufficiency. Bureaucratic interlocutors appear to make sense of this conflict by recourse to personalizing moral failings of laziness and entitlement among citizens. It is these ethical evaluations that guide their ethics of care in significant ways.
Rethinking Development and Dependency

In only two cases did I encounter bureaucrats who attributed dependency to government structures instead of the moral character of Batswana. I met these individuals, Rra Lentswe and Mma Viviane, in Gaborone in the lead up to the first NGO Council conference uniting stakeholders and NGOs across the country. Rra Lentswe worked for a network of community-based organizations that operated primarily in remote areas. He proposed that it was the government’s implementation of a top-down model of development planning that led to disempowerment among citizens and a high rate of dependency.

Although in my other conversations and interviews, officials (both elected and appointed) expressed that development should come from bottom-up and that Batswana must be led to take part in “self-help” programs, Rra Lentswe argued that this was not what government officers wanted. Rather, the government did not want an informed or empowered public, who would be more demanding of their public officials and aware of their own rights. As he put it, “We don’t have solutions for eradicating or dealing with dependency syndrome. Our government is the agitator of dependency syndrome, because – truly speaking – the current governmental system does not like empowered people because they will know their role and their rights.” He continued,

The reason why is that when you [a councilor] get to the kgotla, you come with your own mandate, you are not summoned by people to answer. That’s where there is disempowerment. We do not have this mentality like the Americans, who talk about the motto “help people to help themselves” – we want to give the people a fish to eat, not to teach the people to catch a fish.

In this interpretation, the fact of continual dependency was established by the design of the programs themselves and indicates the ways in which bureaucratic care becomes a tool to lock-in asymmetric power relations.
According to Rra Lentswe, there was indeed a problem of dependency in Botswana, even one that related to the “mindset” of its citizens. In his critique, however, this mindset was cultivated via government efforts. He drew a spatial representation to explain the dynamic to me (see Fig. 6). He told me,

Development in Botswana is like this: a concentration of development in the densely populated areas. As you go out along the spiral, the development becomes weaker until you are in the dark. Developments are all centralized in this country. Those in the inner circle are aggressive toward development, those in the outer areas are fearful. They live in fear. That’s the mentality or mindset of the people.

![Figure 6. Rra Lentswe's Spiral of Development in Botswana. Replicated by the author.](image)

This diagram mapped out the increasing rate of dependency as a spiral outward from the center of the development apparatus, which was concentrated in large towns and villages. According to Rra Lentswe, those in the “inner circle” of development have low rates of dependency, while those on the outer edge have a high rate. The higher the concentration of development resources, the lower the current rate of dependency in his schema. Rra Lenstwe’s perspective was certainly informed by his decades of agricultural work with remote rural communities, among the most impoverished sector in Botswana. Yet in a place like Serowe, the natal village of the President
and ruling lineage, with a history of development and VDCs, why did dependency remain such a persistent thorn for officials? I asked them what they thought about the new push for “self-help” entrepreneurial programs and the possibility for empowerment.

Mma Vivian who (after many years working in the Gender Affairs office for the national government) now worked for the NGO council, believed that these programs were not designed to be effective. First, they were not designed with any consultation of the potential beneficiaries, but represented more “top-down” intervention. She expressed the dissatisfaction that most people felt about the programs, “It’s like that everywhere! People simply aren’t involved in the planning of poverty eradication.” She gave the example of the new “gender affairs grant” designed to provide start-up funds to women (single or groups) to start small businesses. The problem was that the grant was not designed realistically, and it led to the backlogs, over-extended capacity, and problems that village bureaucrats expressed to me. Mma Vivian explained,

Now people see these guidelines as something that will change their lives. That is not the case. What is here is just unachievable. There will be thousands – well, everyone – applying because they do not have an age restriction, all family members can apply. If you consider that, and imagine what will come out of it, the department of gender affairs has no capacity to handle the influx. As the politicians go out, they’ll be told by the people ‘We have long submitted our proposals and Gender Affairs is refusing to give us money,’ then what is the case? The minister here will be called in, and he will summon his staff who will say, ‘we can’t cope, we are limited on the ground.’

Rra mentioned at his point that there were 700 applicants for this grant per day in Gaborone. This was far beyond any capacity of the program, and certainly beyond the allocated funds. For this reason, they believed that the program was never designed to meet actual need, but to create the “image” of a state that cared for its people.

Although these two bureaucrats did not represent a majority viewpoint among my participants I attend to their interpretations in depth because they highlight crucial structural
factors that were absent from other bureaucrats’ narratives. There are complex political histories and institutions that act together to promote a caring relation between state agents and citizens. On a broad scale, this relation provides resources as a form of paternalism over citizens to keep them dependent and attached to the political party. At the same time, since state-formation is open-ended and sometimes contradictory (Bierschenk and Sardan 2014), individual officers who faced citizen demands every day lament the dependency that had come to characterize the relation.

Conclusion: Transforming the Ethics of Dependency

Ferguson’s (2015) recent work on distributional economies pushes us to re-conceptualize dependency outside of its pejorative or shameful connotations. Ferguson notes that development has long been conceived as a struggle against economic dependency. Yet those with few resources often seek out relations of dependency to survive, which conflicts with the policy goal of self-sufficiency for the poor. Historically in Southern Africa, hierarchical dependence (on chiefs then employers) was a “principle mechanism for achieving social personhood” and membership (146). As Ferguson notes, to be dependent on someone is to be able to “make at least some limited claims on that person” (ibid, 146). In the case of caregiving households, in providing caring labor for a dependent person, caregivers may now direct such claims at the representatives of the caring state.

Bureaucrats, conversely, offered a formulation of dependency more closely tied to the ethos of development. The framework of development as a vehicle to achieve more productivity and self-sufficiency among the population stands in tension with historical forms of benevolent political hierarchy in which belonging is based on dependency networks. I argue that the empirical rationales of bureaucrats, though they ultimately blame the poor for their own predicament, do not simply replicate Western logics of autonomous workers. Rather, their ethics
reflects the push-and-pull of both autonomous and collective personhood in Botswana and the conflicting historical logics of Tswana politics and development.

The government officers cultivate an image of the state in which they are responsible for its neediest members. In practice, the distribution of material resources is also part of a disciplinary model in which citizens should strive for certain ideals and comport themselves in specific ways. The link between distribution and discipline, despite being shadowed by a fear of dependency, establishes a power differential of the authority of the state and its agents. Within this power dynamic, I assert that allegations of failed or limited care provide a mode of critique from both citizens and bureaucrats when different expectations of the other party come into conflict. A “conflictual ethics of care” demonstrates that concepts of failed care emerge from different values underpinning legitimate dependency and different perceptions of the structures of economic precarity.

In the next chapter, I expand on the hierarchical dynamics of bureaucratic care in terms of the marginalization of the Basarwa population in Serowe. This population is often subject to the dependency and irresponsibility narratives discussed in this chapter. It is important, however, to understand the historical and cultural context of the Basarwa in Serowe and the ways in which a narrative of cultural (ethnic) difference and backwardness has emerged to characterize the caring relationship between Basarwa and the government. I seek to examine how care interacts with hierarchical dependency to replicate marginality, which gives us a chance to examine how an ethic of care can contribute to the replication of social inequality.
Chapter 7: Ethnicity, Exclusion, and Bureaucratic Care for the Basarwa in Serowe

Ethnographic and Economic Situation of Basarwa Population in Serowe

The Basarwa population in Serowe is concentrated in the north-west edge of the village, making them geographically remote from the village center, or main mall. The only transportation service that runs there are infrequent *combi* buses, and taxis cost extra due to the longer distance and lower volume of customers. Many residents walk for several hours to the main mall due to lack of funds for public transportation. A local development officer described their residence in this area as the result of a government resettlement process during the 1970s. He did not know the details, but this settlement was probably part of the push in the 1970-80s by the government to move Basarwa out of national parks, conservation areas, mining, and farm areas (Hitchcock 2002). Many were resettled into “Basarwa-only” villages, like those just outside of Serowe, called Sehuno and Malatswai. Some left these villages to come to Serowe in a process of “self-allocation,” a common strategy used to force the government to grant land and water rights (*ibid*).

Basarwa households represented 10% of my sample population, and households were concentrated in four specific wards in north-west Serowe. The lone social worker who serves the catchment area (encompassing all these wards) told me that she had more than 400 cases to manage, higher than any other social worker with whom I spoke. The Catholic church runs an NGO in the area. When I asked their field officer how the organization determined who was Basarwa for the programs, she explained that they use the wards as a geographical proxy and serve the youth living there. This speaks to the on-going spatial dimensions of the definition of
the Basarwa minority, historically tied to residence outside or on the periphery of villages (Motzafi-Haller 1994).

The government does not collect census data on ethnic affiliation in Botswana. This emerges from the nation’s “race-neutral” policy that emphasizes national identity above ethnic affiliation. For this reason, collecting data on ethnicity must be handled with sensitivity. Rather than ask respondents directly for their ethnicity (*morafe*), we asked the name of their totem, which is linked to specific *morafe*. This strategy allowed participating households to “self-identify” as Basarwa. The average size of Basarwa households (defined as the co-habitants of a single *lolwapa* or yard) was 12 full time residents, although numbers had a large range from 6 to 28 inhabitants. For comparative perspective, the average household size across my larger sample population was 6 residents in a yard. The subset also relied heavily on aid; 77% of Basarwa households were enrolled in a food basket program for the destitute or orphan care. This is comparatively high, as among non-Basarwa households only 48% relied on food or orphan aid.

My surveys indicate a high rate of unemployment; 12 of 13 Basarwa households reported no formal employment among residents. The primary employment opportunity (for men) remains low paid agricultural labor as “herd boys” at the cattle posts. This entails movement back and forth or long stays outside of the village at the lands (*masimo*). This option is not always a desirable form of labor. Boikanyo, a young man in his early 20s, described to me why he resisted going to work there even though he had no reliable source of income. He told me,

> Sometimes I think of going back to take care of people’s cattle, but I know if I do I’m going to suffer. I was working at the cattle post but I had to stop because I was sick, and the people I worked for were not taking care of me or checking on me. These days, I’m thinking of going back if I do get some money but just to get my clothes so I can come back and stay here. What can I do? Working there is very difficult.
The identification of an absence of care serves as a marker of failure in a social relation that should provide support or aid. My Basarwa interlocutors, despite being beneficiaries of state aid, described limits and failures of care in many aspects of their lives.

In this chapter, I return to the lens of empirical ethics to examine the rationales that emerge to explain the limitations or failures of the welfare apparatus from the points of view of bureaucrats and Basarwa interlocutors. I contextualize these framings within the broader “ethnic project” of my bureaucratic interlocutors that shapes the social categories of difference of Basarwa residents. I examine how empirical ethics interact with the social construction of marginality and dependency to preserve hierarchical relations in the welfare state. I argue that bureaucrats implicitly act from and affirm a hierarchical relation as they deploy welfare “care” as disciplinary technology, reifying ethnic difference as they attempt to create more disciplined assimilated subjects.

Assimilation or Integration in Botswana?

Ethnicity is a charged topic on the continent; the importance of ethnic divisions is often associated with the limited relevance and efficacy of the post-colonial state in Africa (Ihonvbere 1994). In this context of competing ethnic groups within a week state, inequality and welfare retrenchment further increases fragmentation and contributes to ethnic marginalization (Kpessa, Béland, and Lecours 2011). The enduring antipathy between ethnic and nationalist identity informs Botswana’s non-racial policy, which does not acknowledge or record ethnic categories. Botswana is not the only African nation with a subordinated indigenous ethnic group or marginal rural population (Hodgson 2009, 2017). This chapter, however, is devoted to understanding how ethnic marginalization persists in a country with an absence of formal

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ethnicity structures and presence of a strong “caring state” (Leira 1994) without structural readjustment or state retrenchment. I argue that transforming patronage networks into relations of dependency in the welfare state serves as a key mechanism of preserving social hierarchy and Basarwa marginalization.

In Botswana, historically Tswana groups framed their difference from Basarwa peoples in generalized oppositions by what the Basarwa lack or do not share with Tswana (Motzafi-Haller 1995). For instance, Basarwa live outside of villages in the wild (*mo nageng*), they do not speak Setswana, they do not have customary law or visible leadership hierarchy (e.g. a chiefdom) (Saugestad 2001, 65). Given that these practical markers of difference have faded in many ways, what are the contemporary criteria that emerge in bureaucratic encounters that preserve the subordinate ethnic identity of the Basarwa? I attend in depth to the role that bureaucratic care, via welfare structures and the individuals who implement it, plays in this process.

Since the 1920s, both colonial and post-colonial governments have struggled with the “Basarwa Question,” wavering between intervention and laissez-faire stances (Hitchcock 1987). Basarwa have long been on the margins of state control rather than proper subjects of the state. Since the late 20th century, the state has proposed that development will “tame” those at the margin, bringing them into the domain of the state and helping them to settle and “grow up” (Solway 2009, 332). Government consensus since the 1970s has been that Basarwa need to be settled in villages to benefit from government development planning (Hitchcock 2002). Saugestad (2001) shows how this mode of dealing with the Basarwa problem focuses on the extension of public and welfare services, couched in spatial terms of bringing the population “closer” to more developed Tswana citizens.
In Serowe, there are on-going initiatives to bring Basarwa into the state apparatus. Social workers (and a Catholic NGO) track and subsidize children to attend government schools. Development officers organize workshops where representatives of the Land Board and immigration office register Basarwa for residential plots and *Omang* identification cards, which they require to qualify for government aid. The incorporation of undocumented Basarwa into state bureaucracies continues the legacy of informal assimilation (Solway 2002).

Although this process is on-going and incomplete, I propose that my study participants represent an assimilated Basarwa population. When I describe the population as *assimilated*, I am referring to a few key criteria: 1) The (formal or self-)allocated residence of households is within village limits, 2) Basarwa languages have been replaced at home by the use of Setswana, 3) The attenuation of historical land use patterns, specifically foraging as primary subsistence, 4) the increased surveillance of government school attendance among children and youth, and 5) The high usage of government aid programs including destitute food baskets, orphan programs, and housing support to sustain these households.

**A Note on Terminology**

My analysis starts from the premise that difference between ethnic groups in Botswana reflects material, institutional, and discursive or labelling practices. The markers of difference become “real” and mutually enforcing, as these labelling processes have concrete and material effects on the lives of those so labelled (Motzafi-Haller 1994). The issue of language and labelling is especially thorny for the Basarwa, and I must make a note here on terminology. The peoples currently assembled under the term Basarwa are not a homogenous group. This term is used to identify peoples from the Kalahari who were “of hunting and gathering origin” (Hitchcock 2002, 229), but this includes as many as 80 diverse linguistic and cultural groups,
who do not have a singular name for themselves as a people (*ibid*). For this reason, these peoples have lived with the labels of others for centuries. I will primarily employ the term Basarwa as this is the Tswana language word that my interlocutors applied most often. The pejorative term “Bushmen,” originally applied by Dutch and Boer settlers, was the more common alternative among speakers rather than the academic label “San,” which I will employ when referring to scholarly literature. All three of these terms, as well as the variant Masarwa (with the prefix -*ma* for thing rather than person), apply to people of lower social status in contemporary Botswana (Motzafi-Haller 1995).

It is also noteworthy that anthropological inquiries have played an instrumental role in the construction of this ethnic group and category. In fact, I propose that anthropologists and researchers have engaged in their own ethnic project (a term to which we will return later) of identifying and reifying San peoples as proto-typical foragers. From the time of colonial contact until relatively recently in the 1980s, San foraging groups became the symbols of our early ancestors or “living fossils” isolated from history and modernity, who could be studied for insight into early human evolution (Motzafi-Haller 1994, 539). Although couched in scholarly objectivism, researchers selectively sought out isolated or “pristine” hunter-gatherers, ignoring those who demonstrated other adaptions in relation to their neighbors and capitalist transformation in Southern Africa (Hitchcock 1987; Kuper 2003).

The interest of academics in creating a static and bounded category of untouched foragers had to do with their own scholarly concerns and evolutionary theories rather than an accurate representation of the active role that such peoples have played in the political economy of Southern Africa (Hitchcock 1987). Yet this anthropological project has had very real and concrete implications that continue into the present. After a brief historical review, I turn to the
narratives of my interlocutors to demonstrate the ways constructions of essentialized difference continue to be applied to contemporary Basarwa communities.

**History of Tswana-Basarwa Relations in Pre- and Colonial Rule**

Archeological research indicates that San peoples have lived in the Kalahari for thousands of years and provides evidence of trade and interactions with agro-pastoralists throughout that time (Hitchcock 1987). When warfare pushed Tswana *merafe* (chieftaincies) from modern-day South Africa into the Eastern and Northeastern edge of the Kalahari during what’s known as the *difaqane* of the early 1800s (Solway 2002), their contact with San groups was one of trade in meat, skins, salt, pottery, and grains (Hitchcock 1987). As the Tswana settled into villages, they continued to rely on San for hunting and other goods. San groups were incorporated into livestock production early on and participated in the commercial hunting of large game as well as playing a prominent role in the fur trade of the late 1800s (*ibid*).

David Livingstone, the first European missionary to enter the area in the 1840s, noted that while some Kalahari groups hid from outsiders, others had attached themselves to influential Tswana chiefs as herders of their large flocks of goats, aiding with harvests, or carrying loads of goods (Hitchcock 1987). This indicates that the Kalahari peoples pursued a range of flexible strategies, either avoidance or accommodation with a certain amount of choice to attach or remove themselves as it suited them (Saugestad 2001). Yet over time, as over-hunting and grazing of the Kalahari placed stress on natural resources, the ability to attach themselves to Tswana pastoralists became more of a necessity for survival (Hitchcock 1987).

Throughout this close interaction, Tswana cosmology and hierarchical political structure underlined ideologies of difference between the Tswana and Kalahari peoples. The Basarwa did not live in villages affiliated with a Chiefly *morafe* as did the Tswana; they were associated with the “wild” or the bush (untamed land), placing them outside of society (Comaroff 1987). In this
cosmology, physical proximity to the village center represented social and moral proximity to the chief (as the center of the polity). The Basarwa lived outside of this arrangement, occupying the lowest social status with limited personhood (Solway 2002).

Indeed, some European explorers reported harsh treatment and abuse of the San (then Bushmen), who were beaten or treated cruelly by Tswana groups including the Bangwato, the founding morafe of Serowe village (Hitchcock 1987). The fur trade made the Bangwato a powerful morafe with expanding territories and livestock holdings. San became herding laborers at the cattle posts for many of the lineage headmen by the 1870s. During this period, institutional changes provided land tenure to Bangwato royalty and headmen, which gave them rights to exploit the labor of people living there (some of whom were San while others were from the Bakalagadi minority) and to exact tribute from them (ibid).

By the time Khama III became chief of the Bangwato in 1875, the system of Bolata, alternately described as “feudal” or hereditary servitude, was in place in the territory. Khama described the Basarwa peoples as vassals who paid tribute to both petty and paramount chiefs, and who could not own anything outright unless gifted to them by the chief (Chirenje 1978). The bolata arrangement not only entailed that they owed tribute to the chief (in the form of hunting goods, such as skins or tusks) but in many cases this relation passed through generations so that they could not transfer their allegiance. Bolata servants were not paid, but instead received “protection, food, clothing, and a place to live” from their Tswana “masters.” This relation frequently took an overtly paternalist tone, as the master undertook to arrange the marriages or to educate his “children” (Hitchcock 1987, 235).

This hierarchy was possible because bolata were categorically excluded from membership in the morafe, unlike foreigners or commoners who were incorporated through the
mafisa system in which the chief lent out his cattle to his preferred clients. Bolata, however, were too lowly in stature for this system and were required to provide labor to royalty and mafisa holders alike. Basarwa bolata could not own cattle, nor could they participate in the kgotla assemblies at the core of political life. This feudal arrangement created strong patronage dependency networks between the Tswana landholders and their servants, and prevented mobility for bolata between social categories.

Khama III declared an end to this practice not long after he became chief in 1875, but many headmen continued to practice it well into Protectorate colonial rule after 1885. Hereditary servitude persisted to the degree that both the British government and the League of Nations in 1923 made inquiries into whether this arrangement constituted “slavery” (Hitchcock 1987, 240). By 1931, Tshekedi the next chief of the Bangwato, constituted a special commission with the British to examine the “Basarwa Question” in the territory, which resulted in a special census of the Basarwa and a proclamation in 1936 that slavery in any form was unlawful. It was only in the 1940s however, that the Protectorate government undertook direct action to place some Basarwa in settled villages with police outposts to better control them (ibid).

The concern of colonial officers about the Basarwa question seems to have mainly emerged from the desire to curtail cattle theft and squatting, a growing pattern on the commercial ranch land of the Kalahari (Saugestad 2001). The Protectorate did not put any policies in place to protect the Basarwa; in fact, their codification of land tenure actively harmed and dispossessed Basarwa peoples. Colonial policy created the “Tribal lands” given to the eight Tswana chiefdoms under the system of indirect rule. This policy only recognized Tswana political rule and land-use patterns. Since other groups were not members of tribal chiefdoms, their territories were considered “terra nullius” (unoccupied) and sold or allocated to ranchers (ibid, 97). As ranchers
moved in and used the land for grazing, Basarwa who could not survive on even more marginal land settled around the cattle posts, alternately viewed as squatters or agricultural labor for herding. Their dispossession persisted after colonial rule with the 1975 Tribal Grazing Land Policy, which zoned “communal” tribal lands for commercial leaseholds and ranches and ejected informal residents of the cattle posts, many of whom were Basarwa. It was during this time that some Basarwa groups in the Kalahari began to organize more systematically for land rights and subsistence hunting (Hitchcock 2002, 2011).

**Are the Basarwa “Indigenous”? A Postcolonial Paradox**

Since the late 1980s, Basarwa/San advocacy organizations have emerged to push back against the state and its policies toward the Basarwa as remote area dwellers (Saugestad 2001). San organizations came into conflict with the state over the attempt by the government to relocate residents of the Central Kalahari Game Reserve (CLGR) to new government settlements (Hitchcock 2002). The government proposed that this was an effort to help residents access the same services as other citizens, while many residents interpreted it as a move to force them from their ancestral lands so these might be mined for diamonds (Hitchcock 2002; Haram 2005). Basarwa communities in the Kalahari began to claim an indigenous identity as their connection to the land, which was a very controversial approach (Solway 2009).

The concept of being an “indigenous” group in Botswana (and Africa) is controversial due to negative connotations that the uniqueness of the group conflicts with the ideology of national unity that legitimizes the Tswana state (Kuper 2003; Saugestad 2001). During colonial rule, all African peoples were labelled “native” in relation to European populations and were original inhabitants compared to them (Pierre 2013). Some politicians argue that label cannot apply to the Basarwa because all Batswana are indigenous except those who migrate for citizenship (Hitchcock 2002; Saugestad 2001). In the postcolonial era, politicians argue that the
term creates divisiveness in society. It is therefore not in the interest of Basarwa to single themselves out as a special category or differentiate themselves from other citizens. Instead, from a governmental perspective, the best remedy is poverty alleviation measures and labor market opportunities to better integrate them into the larger national body (Saugestad 2001).

This term is useful however, as an analytical lens on the relation between a minority group and a dominant society. It draws our attention to the structural position of the Basarwa vis-a-vis state institutions. The term focuses on the postcolonial “internal” set of relations within a state; a group is indigenous only in relation to another encompassing group who control the state infrastructure (Saugestad 2001, 53). Having briefly reviewed labelling practices (and controversies) as well as the historical interactions of Basarwa with dominant ethnic groups, I turn now to contemporary policy dimensions of ethnic difference.

The “Neutral” State and Minorities

Scholars have described Botswana’s policy toward minorities as “non-racial” or “neutral” (Saugestad 2001; Solway 2002), because it contains no recognition of Basarwa or other minorities as distinct ethnic groups. There is, however, a de facto recognition of their distinct status in the Remote Area Dev Program (RADP) which began in 1974 (Saugestad 2001). The RADP is a “welfare program” that uses socio-economic, rather than ethnic status, as its criteria for assistance (ibid, 31). A welfare-based approach, however, only serves to increase dependency or “clientification” of the target group, which helps preserve their subordinate status (ibid, 31).

It is helpful to put national policy in historical context to better understand why Botswana took this neutral policy tactic (Solway 2002). Botswana’s approach to non-racial/ethnic policy emerged from the racial project of colonial rule. As Pierre (2015) argues, racialization is “the construction, constitution, maintenance of racial categories and meanings,” which was foundational to the model of indirect rule (4). This form of governance relied specifically on
nativization, the separation between “Natives” and Europeans. Nativization operated through the reification of different tribal categories administered by colonial authorities. During independence, political leaders accomplished the transition to a national identity by managing “tribal” differences, leaving intact underlying economic and political structures supporting white supremacy (ibid, 35).

The government of Botswana pursued neutral policy to minimize ethnic identification to promote a unified national identity. The neutral policy also underlies an assimilationist approach that assumes cultural similarity is the basis of all development (Solway 2009). This was achieved in practice by elevating the model of the Tswana chiefdom to a “neutral” or hegemonic standard as the main symbol of a culturally homogenous state (Solway 2009; Saugestad 2001, 28). For example, citizenship was initially based on membership to the eight Tswana merafe, Tswana land tenure systems became national land policy, and Setswana and English were implemented as the languages of instruction in school. Ethnicity retained its link to tribalism, while “unity” became a central governmental value that persist until today. In 2016, Botswana’s 50th independence anniversary celebrations used the official slogan “United and Proud” (see Fig. 7).

![Figure 7. 50th Anniversary of Independence Slogan: “United and Proud.” Photo by author.](image-url)
Despite the implication of this slogan that all Batswana citizens are united in social standing, there has never been any initiative to address discriminatory attitudes from the majority population toward the Basarwa (Motzafi-Haller 1994). Yet such attitudes are a pervasive and under-acknowledged aspect of the interaction of Basarwa individuals within the welfare apparatus. In fact, politicians from Basarwa areas of the village acknowledged this problem to me. Rra Sego explained, “I’m not happy with the way people live here in the ward. Some of them are neglected. They are denied services because they are looked down upon. For example, the orphans are only helped after a long time, even though they’ve been told that we [the council] will help them with school uniforms.” Caregivers from Basarwa households also shared stories of poor treatment. Sara, a young woman who helped care for grandfather, told me she and her grandmother had given up seeking help, “We are now scared to go to the social workers because they are not bothered [to help]. You can go to them and when you get there they will just close the door and tell you they will be back soon and then they never come back.” As these narratives show, welfare policy that is ethnicity-blind does nothing to prevent interpersonal practices of discrimination because it puts no protections or mechanisms in place to address them. I now shift to my ethnographic evidence to discuss the contemporary forms of difference that characterize Basarwa interactions with state apparatuses.

**Tswana-Basarwa Patronage: A Case Study**

The relationship between indentured labor, social hierarchies, and ethnic categories has transformed but not disappeared since the era of *bolata* servitude. I met several prominent families (linked to the royal Bangwato lineage) that still relied on Basarwa families – now as paid domestic or cattle workers – who had served them for generations. I examine this evolving relationship through the case of a former patronage relationship in the area where I lived.
Mma Buku was a member of a household that had served a high-ranking Tswana family for many years. This family belonged to the primary lineage in the ward where I lived during fieldwork, which was in fact named after them. Next to the yard where I lived was one of the largest yards in the ward. It had belonged to a former chief, who as well as serving as chief was a highly-educated doctor and diplomat. Part of the reason for the size of the yard was that up until the 1990s it included upwards of 14 rondavels that housed Basarwa households, primarily the female partners and children of the cattle post workers. The doctor’s grandchild (who still lived in the yard) informed me that he took care not only to house and feed the families but to pay for their clothes and education. During this time, Mma Buku lived in the yard with her children. This offers some insight into the dimensions of care that such arrangements might entail, but also their fragility as they depend entirely on the good will of the patron.

In this case, the arrangement abruptly ended when the doctor passed away in 1998 and his widow “evicted” the families from the yard. Mma Buku, and her children and kin, re-settled in the north-west area of the village where they were allocated their own plots next to each other. At the time of my research, almost twenty years later, I met Mma Buku in her early 60s as she struggled with her own health issues while caring for her elder brother who could not see or walk. The two survived with a destitute food basket and relied heavily on her kinswoman who lived next door (who had also lived with her in the doctor’s yard). Her brother had qualified for a small house through the president’s housing appeal and they lived in a canvas tent while waiting for the construction to commence.

When I returned in 2017, Mma Buku passed away at the age of 64. Her funeral arrangements were stressful for her family because funerals last up to seven days and are quite costly. There was a lot of uncertainty about when the funeral would be scheduled and whether
the children could pay for it. Mma Buku, as a destitute person, received some government subsidies for funeral costs, including a free casket, fees paid at the mortuary, and a food subsidy of grain and cabbage. The social work office did not cover other significant costs however, including the animal to be slaughtered or the rental of dishes, chairs, and tents for the funeral. The doctor’s grandchild informed his widow of the funeral as an opportunity for her to contribute. The widow, who was out of the country, did not offer any financial assistance or attend the funeral itself, nor did any of her children. She was not in contact with these families at the time of the death and at no point did she contact them. In this case, the previous patron relationship was severed, it inhered entirely in the doctor who felt responsibility to his Basarwa as “dependents,” and was easily set aside by his wife.

At the time of the funeral, I learned that the old woman had joined a local burial society who raised money amongst themselves for funeral costs. She had also joined a spirit church, whose members contributed to and organized much of the funeral ceremony. After I attended the funeral, several friends asked me if I had noticed a difference in the people at the funeral, presumably because many of them were also Basarwa. When I asked what difference I should have noticed, they suggested for instance the number of babies of the women. I recount this case because, combined with Boikanyo’s testimony in the introduction, it indicates that there has been a transformation of the “caring” patronage relation between Basrawa and majority groups. This has now largely been replaced with new combinations of welfare and local self-help groups that help Basarwa subsist despite the persistence of poverty and inequality. Care continues to operate, however, to serve hierarchical differences between state representatives and Basarwa people.

**Basarwa Difference as Racial-Ethnic Project**
Given that there is no formal recognition or state distribution mechanisms based on ethnic affiliation, the question remains about how marginalization and status hierarchies persist in such a setting. Motzafi-Haller (1994) argues that social categories of difference persist, not in policy, but through interpersonal interactions and the legacy of historical markers of difference. I examine this dynamic by attending to the views of bureaucrats in the village; including social workers, development officers, and district councilors who interact routinely with Basarwa citizens. The ways in which interlocutors framed concepts of difference emerge entirely within the logic of bureaucratic care as a disciplinary apparatus, as they attempt to render Basarwa governable subjects within the welfare apparatus.

I want to draw specific attention to the way that bureaucrats’ narratives contribute to the social construction of difference akin to the concept of a “racial project,” which assigns meanings to race within a social structure through imagery, discourse, and interaction (Pierre 2013; Omi and Winant 2014). Race is a folk conception of hierarchical difference based on inheritable biological and phenotypic traits (Smedley 1998). I modify this lens to reflect the fact that in Botswana, the language of “ethnic” difference replicates essentialized cultural traits rather than essentialized biological underpinnings. Yet racial formation theory, the process of constructing the social meanings of hierarchical difference, remains useful as ‘culture’ has replaced racial essentialisms and ethnicity taken over its conceptual role (Allen and Jobson 2016; Kuper 2003).

In the case of the cultural difference of the Basarwa, much like racial projects in the US, the significance of the category both exists in relation to a larger status hierarchy and is linked to unequal distribution of resources (Omi and Winant 2014; Feagin 2006). Additionally, the difference between racial and cultural otherness can be murky in practice, as some of the forms
of difference that mark Basarwa show slippage into biological traits. For instance, I witnessed regular jokes made about “Chinese eyes” – pointing out the almond-shaped eyes that some Basarwa people have. Though I did hear stories about inter-marriage between groups, this is still stigmatized – as when a friend disbelievingly asked me why a Mongwato woman had chosen to have a child with a Mosarwa man.

In this section, I will identify the most common markers of difference used by interlocutors to distinguish Basarwa peoples. It’s quickly evident that many of these markers relate to the task and ‘challenge’ of governing or assimilating the Basarwa. This reality is summed up in the saying, relayed to me not only by an informant but by friends and my research assistant, that “You can take the Bushman out of the bush, but you can’t take the bush out of the man.” The “bush” contained here is symbolically loaded, representing the “wild” and untamed physical space outside of society, and the effect of that wildness marking the culture and nature of the Basarwa person in an essentialized way.

**Nomadism and Mobility**

There is a strong ideological association that came up in interviews primarily through the reference to Basarwa as a mobile or “nomadic” people characterized by constant movement. For instance, a development officer described this as a challenge for implementing government programs when he told me, “The Basarwa are nomads, they move from one place to another, so they apply [for programs] and then go. They migrate and sometimes when you go to check them, you find they’ve gone to the cattle post or somewhere else, follow up is hard.” A district councilor from the same area told me to remember that “these people are nomadic, so they didn’t have a residence of their own. They usually are prone to self-allocation, we’ve had a tedious process of securing them plots.”
This nomadism also appears to be linked to an aversion to living within the village. A social worker described their preference for certain government programs, “For Basarwa there is only one [program] they want, the small stock [goats]…so they can keep them at the cattle post and stay there.” Some interlocutors drew a distinction between the Basarwa who had chosen to settle down, as when an NGO worker said that Basarwa children “who are in the villages are more settled. But some of them are always coming and going, either their parents work at the cattle post, or this or that. Now some are settled. But they find it difficult [to integrate].” The head of the Catholic NGO also merged a historical subsistence pattern into a model of cultural preference. She told me, “They are not cultivators by nature. The land boards are experienced Batswana, they will say ‘Sister, why not use it [land] if they have it? But they must go slowly.”

The perceived mobility of the Basarwa became problematic when it interfered with children’s schooling. Bopelo, a field officer at the church NGO told me that programs often did not work for Basarwa because they would take off and “disappear for 3 days.” He continued to explain that many would pull their children from school. He said, “Sometimes we go with the social worker to see the children who are not going to school. Parents will take them [to the cattle post] and they’ll just say, ‘look after the goats, we will stay here and drink milk, life goes on.’ They do not see the future, what will happen next.”

The concept of mobility was closely linked to their physical distance from village life, both emerged in descriptions of the difficulties of governing the Basarwa. In the following section, Bopelo (who works closely with Basarwa) goes on to link their “culture” not only to spatial distance, but to a sort of unruliness that leads them to do “whatever they want.” In this passage, he describes government efforts to reach the Basarwa:

When it started, they organized them at first when they were far from Batswana because they wanted to bring them closer. They were right in the bush. Their
culture, you can’t control what they are doing, if they want to sleep under the unprotected transitional houses, that’s what they want. They eat whatever they want to eat in the Bush. But we realized this is not good, it’s not healthy, they have to come down [to the village]. So that’s when we started to bring them down here to bring them next to people. That’s when the housing project started immediately.

Cultural Personality and Mentality

Other bureaucrats foregrounded collective Basarwa personality traits. For instance, a development officer Rre Obonetse described to me that, “Those Sesarwa speakers like to isolate themselves and stay on their own. They are not people who like to mix with others. Those who can live with others are few, although there are some we have taken to be our wives.” Although he did not question their intelligence, and remarked that they had “God-given gifts” and could do extremely well in school given certain circumstances, he went on to attribute a cultural mentality that held them back. He explained, “Even if the person has gone to school, even to university, they will change and behave like a person from MM [ward]. We have many who have finished their secondary schooling Form 5, even at UB [University], but they come back and prefer to sit down and be busy drinking alcohol. It ends up delaying them, it’s their origin (ke letso).”

One of the council members for that region of the village went into greater detail about the role of their culture in creating a different mentality, which manifested in their relationship to government aid. He told me,

They do get food baskets, the problem with that community is that, their tradition and culture, they’re not like Batswana – although slowly but surely, they’re mixing with Batswana. The problem is they are not used to those food baskets. They say, ‘oh, in life you can receive a food basket just like that.’ So, in that case they can just sell the food if they want to drink or get alcohol. They will sell the maize and rice, just to be left with tea and little things. They’ll do that. Even those that are sick, they can do the same thing.
Bureaucrats and NGO workers also posited an ahistorical “cultural” mentality at the root of perverse forms of sexuality and reproduction in the Basarwa community. For instance, Bopelo described to me his efforts to educate Basarwa youth about proper romantic and sexual relations and described their problematic cultural preferences. He gave me an example, “In MM [ward] you’ll find that the youths they might be going out with a third cousin, and end up having a child together, and this will go on and on in a chain without them realizing. Their minds are blocked or something, it’s a big challenge that they go out with their relatives.”

**Sexuality and Family Size**

Many people (during interviews and in general conversation) also told me that Basarwa women had too many babies. Different development officers described to me how big the families could get. One told me, “At times you’ll find that 10 of them are staying together even though there will not be any source of income in their lives.” Rra Obonetse went even further exclaiming that “sometimes you’ll have those who are staying 25 of them as one family.” A district councilor from this area told me that government efforts to build houses was difficult because of the growing size of the population. As he put it, “[Housing] not enough for them. They give birth a lot (*ba tshola thata*), regardless of age. The main problem in the ward is the way they give birth so often, there are so many children, it is too much. Even the underage girls are giving birth and they drop out of school because of that.”

The anxiety about birthrates was related to an overt sexualization of Basarwa women as well. This did not occur within my interviews but in casual conversation with different acquaintances. In one instance, a man remarked to a female friend that she had large buttocks “just like a Masarwa,” which was good for anal sex. During a different conversation, the male cousin of a friend of mine was talking about relationships and mentioned how much the Basarwa
“loved sex.” Later I asked my friend why he singled out Basarwa people like that. She told me (as though it was obvious) they you know they love sex because of the number of babies that they have.

**Alcohol Abuse**

Interlocutors repeatedly mentioned how much the Basarwa “like alcohol.” This is a troubling example of the way that the effects of long term social and economic marginalization become coded in pathological cultural tendencies as the “preference” or nature of certain ethnic groups. This phenomenon is not unique to Botswana⁶. Across the globe, indigenous groups that have been colonized have higher risk of alcohol use disorders and risk of harm from alcohol (Brett et al. 2017). The mention of alcohol use among the Basarwa was so common that I share just one quote here from a social worker. This quote is representative of the description of behaviors that I heard, with only vague or indirect reference to possible social factors (in this case unemployment):

The problem with these people is that they drink a lot. Like now, there is a law that you can only open [home brewing operations] at 2pm, but if you go around here you’ll find them inside a house like this one – they don’t go outside because these police clusters intimidate them. They will lock themselves in the house and drink in there, even from this time [about 8:30am]. Around 2pm, they start coming out, very drunk. You’ll wonder where did they drink since they’ve long been drinking. They just wake up and go… the problem is that they have nothing of their own to do, nothing of their programs to follow. The only program that they have… is if they have a place that they can drink, 3 km or 5 km away, they will disperse to those places. They will only come back during the night around 10, 11, 12 at night.

There is a common thread throughout these narratives that embeds the markers of difference within the project of governing the Basarwa and the legacy of their “unruliness” at the

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⁶ For example, see Brady (1995) for North American and Australian context, Herbert et al. (2017) for case of the Maori in New Zealand, and Butler (2006) for Quichua speakers in Ecuador.
margins of society (e.g. “they do whatever they want in the bush.”) These tendencies must be curbed via education and integration “for their own good.” Having discussed the social construction of differences, I now turn to the ways that bureaucrats use such differences to understand the failures of bureaucratic care.

**Governing Basarwa through Bureaucratic Care**

My ethnographic investigation reveals how “ethnic projects” (analogous to processes of racialization) operate in encounters between representatives of the state and citizens. In these encounters, actors entwine ethnic projects of difference with ethical formulations of need and deservingness. I use empirical ethics elsewhere in the dissertation to examine the breached social expectations that surround the provision of care. Bureaucrats labeled distributive strategies among citizens more broadly as “dependent” or “lazy.” When referring to Basarwa, these same labels were attributed to essential cultural differences, reinforcing discriminatory beliefs.

Many bureaucrats framed their interaction with Basarwa citizens in terms of challenges, often describing a fundamental ignorance on the part of Basarwa residents. The councilor Rra Sego gave me a specific example, “As you know people in MM [ward] they live here but most of the time they don’t know the things going on in their area. With their lifestyle – like in the morning, you’ll find they’ve gone to harvest the mogorogorwane (wild berry), just for two months’ time. They will even take their children from school to go there for harvest… but I make sure I tell them it’s wrong. School is more important.” In this narrative, he uses foraging for berries (a survival strategy) to position their basic ignorance about the importance of education, closely tied to development.

The parliamentary liaison for the North-West area of Serowe confirmed the sentiment that marginality and ignorance of development programs go together. He explained,
We say are they are marginalized groups because somebody who needs help is somebody who is functionally illiterate, somebody does not know the surroundings, who wouldn’t know to go to the registration office to get an Omang [ID card], who does not know there is a program that is being done by the government, either Ipelegeng, SHHA, or the LEA where we groom entrepreneurs. They do not know any program or policy that is being developed for the people. That person who doesn’t know those policies, is the person who lacks representation.

His list of various work or subsidy programs assumes that it is simple ignorance that keeps Basarwa from taking advantage of them, which follows the narratives of other bureaucrats that focused on cultural traits of the Basarwa. For instance, development officers in two wards explained that Basarwa people were scared (ba tsaba) of coming to the office for help. Rra Oboneste told me, “In our area people here are Sesarwa speaking people, and a lot of them fear others. They are scared of the office, even though the government is overprotecting them.” He elaborated, “Everything [programs and aid] is here but most of them are scared of the office. Even when we arrive here, they will run away.”

Another common theme that placed responsibility for the failure of welfare provision on Basarwa communities, was to link alcohol abuse to an improper relationship to money. The social worker Mma Sabina was adamant about the challenge that alcohol posed to effective government and familial care. She told me,

The challenge with these ones when they get on Home-based care or destitute package [food basket], they can go and sell it and drink beer. They tried it too for the student packages, they do sell it... They drink. They even leave the patients and go out. They can leave their patient and go to the lands and stay for parties, with traditional brews… It’s a challenge because majority of them, 98% of them do drink.

Similarly, a district councilor linked alcohol consumption to their attitude toward money when he said, “They want quick money so that they can drink every day. That’s why they like piece
jobs for fast money that they receive right away, even if it’s 10 pula – they can have a party with 10 pula.” Thus, alcohol fueled an irrational relationship with money, which provides a cultural reason why they took short-term low paying jobs, rather than addressing the structural dimensions of employment discrimination for the stigmatized population.

Bureaucrats invoked these sorts of traits to explain the persistence of poverty and marginalization, which simultaneously allowed them to justify the even greater reach of bureaucratic structures. For instance, the poverty of Basarwa communities (blamed on their drinking and cultural mentality) could be dealt with by managing and transforming them into more responsible and culturally homogenous subjects. Interestingly, one of the members of the VDC in the north of the village explained this to me with what he called “affirmative action.” I realized however, that he was not speaking about quotas but about targeted re-settlement of Basarwa people. He reiterated the long-standing idea that development depends on village settlement. As he put it, “Affirmative action works with them [in the village] just like in Malatswai where they’ve brought them together in one place, they’ve built a school, they’ve put electricity… Now people of Malatswai they have developments and they are now living like other people.”

Another district representative also invoked “affirmative action,” which blends development as provision of services (e.g. water) with cultivating specific subjectivities:

We’ve even gone to the extent of looking for the Basarwa through the affirmative action program and tried to gather them from where they are staying where there is no water or electricity. That is why they are a part of this ward here… They were from the remotest areas. What they do, they stay all over – anywhere in the bush. The government has been working on pushing them to the nearest settlements and villages so that we are able to provide for them.
I argue that welfare initiatives providing basic needs such as water and electricity, which I include under the lens of bureaucratic care, must be understood in the context of the larger project to “develop” Basarwa by making them more like the majority group. This reasserts Tswana cultural hegemony and – in the failure of the government to address the roots of their poverty – it has the effect of constantly reifying differences to blame them for their own marginality.

In chapter 5, I described the close relation between bureaucratic care and regimes of surveillance. This also applies to Basarwa populations, although surveillance becomes closely linked to assimilation. My interlocutors, expressing a desire to help the “needy” Basarwa community, demonstrate that this care relies on a paternalist impulse to develop the Basarwa that replicates ideologies of cultural difference. As we have already seen throughout their narratives, bureaucrats continually reaffirm the need to “settle” the Basarwa to extend government care. Modisa explained the need to move Basarwa communities to provide basic amenities such as water, electricity, education. He explained, “Every kid should go to school… and, as I’ve been saying, [everyone needs] water as well. It is the responsibility of the government to provide water, clean water, to anybody. In Serowe we do not have a problem here, the systems are running. Only that we have a problem where we have some breakdowns, we sometimes have to carry water to the people.” Of course, he is referring only to municipal water systems, rather than alternative options like rights to surface waters or boreholes that might furnish water. This narrative also downplays the reality that many households (both Basarwa and Tswana) in that region of the village cannot access water utilities because their yards are not connected to the municipal water line.
In fact, getting to water to this region of the village has been a difficult and incomplete process. Rra Sego, a district councilor for the area explains why, “Here they hear they are out of map of water utilities so that it takes time to connect the pipe. But it’s too costly, imagine if you are to start building a house and if they measure the meters, they’ll tell you they charge 78,000 pula ($7,800 USD). Where are you going to get the money?” Those who are connected to the water main also struggle because the elevation in the area makes water pressure a constant issue. He continued, “Some have been able to install [pipes] that are part of the supply from water utilities in Serowe. But when we get to MM [ward] which is very high elevation, the water pressure is low and you’ll find the water does not come out. People have to wake up at 3 in the morning, that’s when they get the water.” Water access and the absence of plumbing and sanitation in the area (many yards lack a basic outdoor latrine) were pressing issues for the politicians and officers in the area, yet water is still able to serve as a justification for settlement and assimilation. The assumed lack of resources (such as water) in the bush was typically combined with other paternal logics.

Rra Obonetse described the difficulty of keeping Basarwa youth in school and proposed a government project that made explicit the need to “manage” this population: “I want to build a hostel for them here [in Serowe]. It will be much better for those who are schooling there because they are the kind of people who like to be enclosed. It will also help them to be away from alcohol and drugs, or for others to go to the cattle post. If you can contain them in one enclosed area you can manage them.” He also applied a paternalist logic and the need for surveillance in terms of medical treatment. As he described it to me, “They don’t use the pills properly even though they are given to them. I have talked to the government to explain that these patients should be taken to the clinic to oversee treatment so that if they don’t take them
properly they can be admitted to the hospital where they can take them properly until they are
better, then they can be returned back.”

He was not alone in pointing out that cultural beliefs prevented Basarwa from navigating
their own treatment. Even home-based care volunteers echoed this sentiment, as when Mma
Morula told me,

You are not supposed to use the traditional medicine (*dithare*) when you are taking
the antiviral. Some were saying it’s not a disease, it’s food poisoning they are
suffering from. They ended up dying and then they said these volunteers are not
helping us with anything. But we used to tell them, when people are on ARVs they
are not supposed to take those traditional *mutis* [herbal medicine]. Now they are
seeing that medication is doing them good at all times.

Bureaucrats regularly reiterated that Basarwa people lacked education. Educating them appeared
to be a primary goal of the state, which I propose is part of the project of turning them into
proper (Tswana) subjects assimilated into the hegemonic way of life. Rra Kabo, a village
development officer, captured the uncomfortable tension between assimilation and
discrimination when he explained,

Here in this ward we have many orphans, those with disabilities, and then there is
the tribe (*morafe*) – and I’m not discriminating against the Masarwa – but they
need a lot of help, especially in education. The kind of assistance we want to give
them is for them to get education and to go to school. The government is supposed
to stand up so that they are taken to school. The assistance should be the uniform
package and to be built houses.

His narrative reveals that even the “benevolence” of the state to provide education masks
underlying assumptions about the difference of Basarwa. Governing them is equated with
helping or educating them, serving to replicate the premise of ignorance and ethnic difference.

Other politicians expressed similar paternalism mixed with concern for the standard of
living of Basarwa communities. The counselor Modisa described their situation to me,
We still have a lot to do with people in remote areas, those people who are called Basarwa. They need a lot of help to be brought closer, because they are Batswana (e.g. citizens) as well. You’ll find that you go out there, most of them are abused and they work at the cattle posts, which is not good. They need education, they need all these facilities we have in the villages, because up there [cattle post] we don’t have them. I think we need to get closer to them, our intention is to bring them closer. But the environment at times doesn’t allow them because they are not used to that. They were left behind for quite some time so now we must bring them closer.

His spatial metaphor of proximity versus distance demonstrates the contemporary relevance of historical ethnic projects. Not only does the label of “remoteness” persist, but the physical distance of the Basarwa from village life (once used to justify bolata arrangements) now provides the reason to care for them via assimilation. The abuse that they face – here linked to their economic positioning as marginal labor at the cattle post – can be addressed through education that brings them “closer” to the development of the rest of the population. The narrative obscures the reality that assimilation and resettlement has been happening for decades and many Basarwa are still abused, still relegated to the cattle post. Yet the logic is so entrenched that there is no other formulation of how to improve their lives or social status other than erasing their differences, which in the process simply reaffirms those categories.

This paternalism reflects the long historical arc of a social hierarchy in which providing care, in terms of basic needs like food and housing, has no inherent liberatory potential. Arguably, this form of caring paternalism preserves inequality because it cements the power dynamic between giver and recipient. This helps us to read the mandate to “bring the government” to the Basarwa in a different light. Modisa described to me that “these people are nomadic, they are prone to self-allocation… when the Land Board came, they wanted to evict them.” He described having to convince the Land Board officers to make special arrangements:
Recently a lot of them have been allocated the plots. Remember that if they do not have legally allocated plots, there is no way the government can assist them, like if they don’t have Omang cards, there is no way the government can assist because there is nothing to identify them. Through the ‘taking the government to the people’ program, we have talked to the district commissioner and the Omang officers came here and we registered them here, we made the copies here – we even brought the photocopiers here so that they could all be assisted here. We brought the whole system here.

The premise of caring for the needs of Basarwa citizens is embedded in the governmental impulse to document them and make them visible to the state. Care is rendered in bureaucratic terms as emergent from the proper paperwork and offices. Rra Kabo, a VDC member, explained,

To put water [pipe in the yard], the person needs their Omang and plot certificate…They bring the Omang [ID] we fill out forms on their behalf because maybe they don’t know how to write or speak English, then attach it all together. Sometimes the process is easier because we try to explain [to land board] that they are Basarwa, they do not understand many things, they are still coming up.

Bureaucratic care, as a logic to provide basic needs such as water access and housing, is inseparable from the paternalist view that Basarwa people “do not understand” or are inherently ignorant of government policy. Care and welfare programs are intertwined with rendering Basarwa more governable subjects and assimilated citizens. This is a powerful discursive regime but one that breaks down as we listen to the experiences of Basarwa interlocutors.

**Basic Needs and Neglect: Stories from the Other Side**

Basarwa interlocutors also related the concepts of care to basic needs; but in their narratives, this was a fraught and often unsuccessful process. They struggled with the inability to provide proper care due to inadequate housing, water, food security, and access to income. These resources, and their connection to government sources, comes to the foreground of how Basarwa interlocutors navigate both their exclusion and their belonging to the state.
Mma Buku, whose story offered us a narrative of the historical transformations in patronage networks, defined care for me in terms of her routines with her elder brother. The older man, living with dementia and physical impairments, needed her help with daily tasks. She told me, “I manage his disease, I bathe him, do the washing for him, I see how he’s doing. During the day, I cook for him because he has pains. It goes like that every day.” Her caregiving depended on securing resources from government offices, which was also a lot of work for her. She was responsible for collecting his pension money and purchasing food with his subsidy. She explained, “I go to Rakgomo ward to help him with food, he has a food basket from the government. I sometimes take Mma Bolao [her neighbor and kinswoman] to help with the pension money… I didn’t know how old he is so I went to the Omang office. We lifted him up [e.g. carried him] to register him to start taking a little money for the pension.” In this case, the government was not “brought to” her or her brother but secured through her own labor.

Sara, who told me of the time social workers shut the door in her face when she went to their office for help, spent a great deal of effort securing the resources that her grandfather’s care required. She told me, “It is very important that when we have a patient at home we have the materials to use for care. That way the patient can be presentable, he has to be clean.” Even this basic precept, that a patient must be clean and presentable, was not an easy task without water access in their yard. Fetching water everyday was its own form of back-breaking labor. Sara continued, “The way he is staying is not presentable, but I am a poor person so I cannot help. I would love for him to be assisted with food and a house to put the food in. My older sister and I we are always getting back cramps because we carry our children and go and fetch water. Now they ask for it [water] far from here and I will have to go get it when the owners are not there.”
These interlocutors did agree with bureaucrats that it was the social workers and VDC members – as the representatives of the President – who should care for the sick and destitute in the village. Getting them to fulfil this responsibility however, was another unending task. For instance, although Sara’s grandfather lived in a one room house that the council had provided him, they had not provided water or a latrine at the time of building. She told me that she had brought up this issue with the local officer. “I asked them why it wasn’t there because when you build a house for a destitute, there has to be a standpipe for clean water, where he can bath and for eating. They just gave him the key for the room and that was it.” Boikanyo, who lived not far from Sara, echoed that the resources for care were very hard to secure from government sources. He told me that his aunt “[She] does not have a proper shelter, and there is not enough food. She used to be on food basket but the social worker removed her. Even water is very hard to get.” They were destitute and had to seek out aid through their own initiative, even though it was the role of local government to locate this type of need in the community. Boikanyo recounted that, “They are supposed to see how we are living, like now we don’t have a pipe. We wrote a letter to take to the social worker.” They were still waiting on a formal response.

His aunt, Mma Ngwane whose story started chapter 6, told me, “I used to go to the social worker to tell her that they cut me from the food basket, but until today she turns me away.” According to Boikanyo, the social worker simply told them “there is nothing we can help you with, so it’s up to you to see what you can do for yourselves.” Boikanyo took the matter to his local development officer. He told me that he had to resort to threats in these efforts, “When I went to see the VDC I told them that if they don’t help me I will go above them to their bosses, that’s when they saw that I was very serious. If you do not have any threats, you won’t get any help.” When my assistant prompted Boikanyo about escalating the matter to the local headman
(a sub-chief), he responded, “We have not yet gone to him. We haven’t thought of talking to him. These people, they will insult us if we go.”

Despite the justification of resettlement and villagization to bring the Basarwa “closer” to other citizens, the experiences of Sara and Boikanyo, among others, indicate that discrimination and neglect characterizes their relations to representatives of the state. In fact, from the perspective of Basarwa interlocutors the mechanisms of bureaucracy do not seem inclusive, rather, they appear most often to be excuses to refuse care. For instance, Boikanyo described his efforts to sign up for the small stock program through which the Ministry of Agriculture provides a small number of goats to beneficiaries. He could not apply for the program without a letter proving that he had water access. He explained, “We wrote a letter to say where we are going to have water for the stock but the people at the office are refusing. They refuse because they are saying they want the borehole to have a certificate.” This shows how even participation in programs designed to help the poorest can exclude them in the layers of documentation required of them. Boikanyo did not own land with a borehole, but even to use someone else’s required time and proof that made the task almost impossible.

Despite this, Boikanyo did not give up his search for a program that might help him subsist. He looked elsewhere, only to find bureaucratic and financial hurdles at every turn. He recounted that, “The challenge with the agriculture program was water, because they couldn’t give me anything if I couldn’t say where I’m getting the water. I went to LEA [a microlending bank] and they told me they wanted me to arrange for the finances but I had nothing. I am going to try for the drought relief program because there is a water stream at the cattle post next to the boreholes.” LEA provides small loans for entrepreneurs but requires that the applicants match funds, making this outside of the reach of youth like Boikanyo without regular cash income.
His aunt and sister also had run-ins with bureaucratic barriers that led to demoralization about government aid. Mma Ngwane told me, “This poverty program is just disturbing me because it has been 3 years since I signed up but I haven’t had any reply from the VDC.” The siblings suffered a setback when a fire destroyed many of their possessions and documents. Boikanyo explains that afterward they had sought help from the VDC, “Since my younger sister’s [birth] certificate burned in the hut, we’ve been to them for help but even now they haven’t helped us. We looked for money to go to the land board to register the plot but now we need 100 pula for the fee, which they want us to pay.” They later experienced the fire that I described in Chapter 6, and with some assistance they succeeded in getting a temporary tent from the district commissioner. But the precariousness of their situation was reinforced rather than mitigated by the bureaucracy that surrounds aid, creating a closed loop between financial resources and documentation that they could not break into.

Mma Buku had a similar experience in her attempts to access government anti-poverty programs. She explained, “I wanted to register for a semausu (tuck shop) in 2012, but they have not responded to me until now. People who I registered with at the time, they were assisted some with tuck shops, goats, chickens – they got assisted. With me now, I am just waiting like this still. I tried to register again but there was no help.” She had all but given up on such options, and her adoptive granddaughter Tumi explained that was part of the reason she had not personally applied for the programs. As she put it, “The old lady got discouraged because they didn’t give her the tuck shop program and because they didn’t reply to her at all, so she decided to think that the social worker is refusing her.”

Perhaps this demoralization and hurt at the refusal of aid was part of the reason that Mma Buku had not perceived any improvement in government treatment of sick or destitute people.
over time. As she put it, “Nothing has changed, it’s the same now as it has always been.”

Although her bother had been registered for both food aid and his old age pension, this aid was tempered by the lack of response and persistent delays she experienced in trying to improve their material situation. This observation was made with a deep resignation, as she remarked at the end of the interview that she had no further comments or requests because, “Even if I comment there is nothing going into your ears or to those in government. I just see that it is the same as always, so what can I ask for?”

**Conclusion: Bureaucratic Care and Ethnic Inequality**

While bureaucratic actors see a troubling dependency “mentality” amongst citizens, this label serves to distort necessary survival strategies and blame the poor for their marginalization. For the poor, “dependency” on others may be the only option. Sara’s words succinctly sum up the harsh reality, “The old man doesn’t have anything, we just survive with whatever people give us.” Survival and dependency are thus deeply implicated with each other, an obvious truth for those surviving day to day. It was also obvious to Sara that she did not have a say in the amount or type of aid, which put her in a relatively powerless position. Even stories of “successful” aid intervention like the old man’s new house demonstrate the profound ambivalence among Basarwa people positioned as dependents. For example, Sara explained that the council built her grandfather his single room without water or a latrine. She told me, “I was not around when they started building the foundation, I was in school. I am complaining now because as children we are too many, the house is just not enough for us. But there is nothing we can do, they have built it.” Her words reveal the double-edge of dependency; while the old man now has a house, it is insufficient to the needs of his family and they remain without a meaningful living continuing to depend on what others give them.
In contrast to this expression of powerlessness and resignation, bureaucrats conceptualize dependency in terms of a highly problematic “mindset” of recipients, associating it with laziness and a “feed-me” entitlement. This framing often applied to Basarwa citizens, as when Obonetse remarked, “They feel that everything should be easy, but we are trying [to help]. It’s just that, these people live like they are not in need of anything. They are given food, money, clothing, they have houses built, so now they are seeing there is no need to take the [poverty alleviation] programs. It’s just laziness.” As I detailed in Chapter 6, narratives of dependency took their meaning from the interpretive framework of development designed to achieve the values of productivity and self-sufficiency among the poor. This framework stands in tension with historical forms of patronage-dependency relations that structured political belonging. The Basarwa occupy a different social space however, because their dependency was marked by essential differences that locked them out of social membership and personhood. The legacy of this relation continues into the era of welfare; Basarwa dependency is still defined in relation to a “benevolent” patron (now the state), but concepts of essential cultural or ethnic otherness cling to them even as state officers argue that they must shed them to truly belong.

Bureaucratic care has failed to produce belonging for the Basarwa because it is not an inherently inclusive set of institutions. The process relies on officers within the state to identify legitimate need, assess, then dispense aid and resources. The narratives of Basarwa recipients demonstrate that within this process their needs are never fully met, they have no meaningful say, and they receive the bare minimum of resources for survival – if the social worker does not decide to cut them off again. This experience of precarity was often expressed by my interlocutors in terms of hunger. For instance, Boikanyo narrated the reality of their food insecurity, “Sometimes she [his aunt] will wake up with something to eat, but sometimes we do
go without food. Right now, we do not know what she is going to eat tomorrow.” Sara echoed this for her household as well, “There is a lot of hunger here. Their pension money is too little for food, because they also have to pay for water.” I propose that dependency on government aid among Basarwa communities is the continuation of long-standing patronage relations of which “care” is a central aspect, which have never provided for their inclusion or social mobility. Currently, “cultural” narratives interact with ethical justifications to mask this historical relation and create an essentialist ethnic project. This elides the discriminatory actions and attitudes from bureaucrats behind a paternalist assumption that Basarwa simply need to overcome their cultural mentalities.

I set out in this chapter to examine how the marginalization of Basarwa communities persists despite governmental regimes of care and liberal ethnicity-blind policies. This pattern continues because agents of state offices justify the ongoing poverty of Basarwa people in terms of their culture; such as their nomadism, fear of outsiders, ignorance, and immature relation to money. Batswana of all ethnicities rely on government aid in their strategies of interdependent survival. Yet for Basarwa citizens, these strategies are proof not only of government exploitation and irresponsibility (as with other Tswana citizens), but also evidence of essential ethnic differences that categorize them as culturally Other. As I argued in Chapter 6, the provision of bureaucratic care is part of a disciplinary apparatus that shifts responsibility for poverty onto the poor. For the Basarwa, the inability to transform into the hegemonic subject of the Tswana state also ultimately reinforces the social construction of difference that locks the community into structural relations of inequality.
Chapter 8: Conclusion

Contributions of the Research

Due to the diverse settings and aims of anthropological scholarship on care, many authors avoid a narrow definition in favor of broader conceptualizations of care. I offer just a sample of the definitions provided by recent ethnographic monographs to highlight this trend. For instance, Stevenson defines care as “the way someone comes to matter and the corresponding ethics of attending to the other who matters” (2014, 3). Han engages care as a “problem rather than a given,” and her analysis “takes it as diffuse and not definable in any simple way” (2012, 24). Garcia similarly avoids an explicit definition, but focuses on “everyday modes of care,” such as gifting heroin, which may seem perverse or harmful from the outside (2010, 9). Ticktin focuses her definition on “regimes of care,” which include humanitarianism, as a “set of regulated discourses and practices grounded in the moral imperative to relieve suffering” (2011, 3). Sufrin (2017) remarks on the “elusive” nature of care as an on-going process in everyday lives, which is not a “distinct category of activity” (21). She uses Stevenson’s expansive definition of care as the ways in which someone comes to matter to focus on three specific dimensions of care: as concern, as relationship, and as practice (ibid).

Like these authors, I attempt to navigate the difficult balance between generality and specificity inherent in the analysis of caring practice and relations. I offer a formulation of care based on the representations of my interlocutors, which is somewhat narrower than the broad characterization of these ethnographers. The concept of care that emerges is primarily relevant to the lives of Batswana caregivers, rather than offering a definition that can be applied wholesale across cultural contexts. I define care as a relational practice comprising emotional and physical labors that maintain the foundational requirements of personhood and materialize the ethical
precepts of social membership and harmonious interpersonal relations. As the cited scholars suggest, however, care as a process and relational mode will change depending on the context and struggles of the persons engaged in it. In Botswana, the definition and the problem of care are embedded in the Tswana ethics of personhood and social integration, as well as the institutional imperatives shaped by development logics and values. Care has specific valence in debates around kinship and welfare systems that would not be legible without acknowledging that the values that shape it are contradictory and uneasily reconciled.

I embrace this ambiguity, and in doing so, respond to the challenge of anthropologists to destabilize the assumed benevolence and transcendent morality of care (Thelen 2015; Biehl 2012; Sufrin 2017). Across analytical scales, from the most intimate interpersonal domain of the family to welfare state institutions, I propose that the ambivalence of care occurs because the practice is always shadowed by fear of neglect, social breakdown, and disorder. Care is morally-charged because it keeps at bay the ever-present inverse possibility; of neglect, dissolution, abuse, and violence. As my interlocutors reveal, it is not the case that once achieved care is a permanent condition; rather, it requires the constant re-production of social ties, human dignity, and well-being. In the contingent process of achieving this state of being, caregivers become aware of their connections and disconnections from others (Han 2012). This is the ambivalence that I unpack in my attention to conflictual ethics and the ways in which caregivers frame this challenging process.

I also dig into, rather than avoid, the ambivalences that shadow institutional care (Stevenson 2014). As others before me have shown, in many institutional settings care and violence are not mutually exclusive (Garcia 2015; Sufrin 2017). The tension between the desired outcome (the care and stewardship of vulnerable populations) and the troubling means of
achieving it (ranging from disciplinary interventions to surveillance and even incarceration) is of interest to me. I delve into this tension in Chapter 7, as the rhetoric and implementation of bureaucratic care contribute to disciplinary formations that replicate ethnic subordination among the Basarwa. In this case, the structural violence being done to the Basarwa operates through the “benevolence” of the caring state and the ways in which this shifts responsibility onto the Basarwa for their own condition, while continually replicating the social constructs of difference that reproduce it.

I propose that the conflictual ethics of care offers a lens to study care while keeping the deep ambivalences and tensions that surround it our analytic frame. It allows me to explore the empirical framing of both ideal care and its impediments, while accounting for how these formulations vary between differently positioned actors. It also reveals the intricacy and diversity of values, priorities, and goals that are at play when people define care, especially in a context of growing wealth inequalities and economic precarity. As Kleinman (1999) has argued, moral experience reflects what is “at stake” for individuals, and my analysis of conflictual ethics indicates how widely these stakes differ between actors who are presumably united in caring for the sick and vulnerable. Among family interlocutors, the stakes of care are not separate from the survival of the household, the challenges imposed by poverty, nor the state of their kinship ties. For bureaucrats, their stake expands beyond the distribution of aid, to the control and discipline of problematic tendencies of dependency and laziness among citizens.

**Care and Inequality in the Welfare State**

Ultimately, the purpose and principle intervention of the research is to foreground the diversity and conflict of perspectives, goals, and values surrounding the concept and social organization of care. I have brought specific relations, labors, and values into view using the “analytic of care” (Sufrin 2017, 16). Using care as our analytic lens reveals significant tensions
that pervade social life, relationality, economic inequality, and governance. Caregiving is intimately bound to the provision of basic needs, the institutions of the welfare state, and an economic system that drives poverty and inequality. The values surrounding the role of care in the social order are not a realm of consensus, but a field of tensions and conflicting claims from different actors as they struggle to define meaningful care amidst material constraints.

I arrived at this conclusion as I sought to answer my primary research questions, which I summarize here before I offer a more in-depth review of my chapter findings. First, I asked, given the ethical importance of care, why do caregivers describe it so often as a problem or limitation in daily life? I discovered that the paradox of care as both present and absent was tied to the experience of caregiving in which mustering the material resources and labor to achieve care (the well-being, dignity, and social integration of a loved-one) was a fraught and difficult process. The achievement of care is evidenced in the production of persons-as-bodies that are clean, fed, and presentable, which signals their humanity and the satisfactory performance of love and devotion by their caregiver. Much is at stake for caregivers, not only the well-being of a person for whom they care, but also their own reputation and moral agency. They are therefore highly attuned to the disconnections or setbacks that occur in this process.

In other words, the paradox of problematic care emerged from the friction or tension between the imperative to maintain social personhood and the material context of poverty and distributional practices in Botswana. Women continue to bear the greatest responsibility for caregiving labor, and often cooperate with a small group of (mostly female) kin to manage these demands. Their strategies affirm the importance of interdependence among different generations and between caregivers and recipients (Thelen 2015). Despite the ability of these strategies to mitigate the worst aspects of poverty and food insecurity, women often expressed the conflict
between the various obligations that they had to shoulder at once. Securing the basic resources for care required constant effort both in terms of wage labor and cultivating relations, and as women experienced setbacks and disappointment they articulated this as shortcomings in care.

Given the Tswana social ethics of *maitseo* (respect and manners), and the ways in which *thlokomelo* (care) bridges domains of loving sentiment and material provision (Klaits 2010), caregivers could perceive the limits of care in multiple domains. Denial or lack of care came in various forms: as dismissive interpersonal treatment, neglect of obligations including the refusal to visit, and the denial of resources needed to achieve care. Interlocutors’ perceived care as present or absent through both the interpersonal dynamics and the aid furnished from specific relations. The rude treatment and refusal of government aid by the state’s agents was evidence of the denial of care, as was the refusal of kin to provide social support or assist with physical labor.

In my second key question, I ask, given the rhetoric of the caring state and its prominent welfare regimes, why does caregiving emerge as a point of tension between citizens and agents of the state? To address this question, I analyze the divergent concepts and ethics of dependency in the context of wealth inequality and economic precarity. The representatives of the state in my study often employed what Ferguson calls the “bogeyman” of handouts and dependency, which prevents more people participating in “productive labor” (2015, 36). In this model, if one simply hands out money to the poor, they will misuse or waste it and lose any initiative to work. Though Ferguson suggests that this comes from development practice, it significantly shapes the culture of poverty trope even in “developed” countries like the US.

While the bogeyman trope should arguably not apply to giving money to those engaged in the “social good” of family care, it never fully leaves the picture. The bogeyman creeps back in because distributional strategies constantly impinge on restrictive boundaries of “authorized
dependency” that only include the elderly, sick, those with disabilities, and children (Thelen 2015; Ferguson 2015, 40). Only authorized dependents are the legitimate targets of government provision, a fact that is codified in Botswana’s official Destitute Policy (Botswana 2002) and CHBC program. This restrictive definition does not easily fit in a world in which many able-bodied men (and women) can no longer access jobs and engage in other forms of labor to earn their share of limited resources. The logic obscures the interdependency inherent in household subsistence, the flow of care and other resources between multiple bodies of various abilities to secure subsistence.

The duty to provide good care offered caregivers a specific rhetorical strategy in which they could appeal for state resources to care for the vulnerable. Ideally, this could be a value or moral good upon which all parties could agree. Yet the drive of caregivers to access resources “on behalf” of their dependents and then to use and control such resources provoked a great deal of anxiety and disquiet amongst both officers and kin about whether the care and love was genuine or just a “cash grab” for selfish reasons. My interlocutors in government offices reacted to this unsettling reality by pathologizing distributional strategies necessary for survival. Their view appears to recognize the strategic work of distributive labor, which uses disability, illness, or other forms of dependency to make claims for distribution, but frames it as illegitimate or predatory behavior. Bureaucrats thus focused on a set of linked attitudes and behaviors among citizens that subverted the rightful distribution of aid; citizens were entitled and lazy, exploiting and using resources for their own needs rather than their dependents.

The empirical ethics of bureaucrats emerged from the friction of contradictory logics; the drive to care for vulnerable citizens alongside a “blaming the poor” model (Greenbaum 2015) that pathologized citizens for relying on state dependency as a survival strategy. This
demonstrates that although the explanatory model of poverty-as-pathology may appear different across cultural contexts, it is intimately bound up with how the state avoids its responsibility for care. For example, in the US, impoverished African-Americans have long been blamed for their deviation from nuclear households, which locks them into a cycle and culture of poverty (ibid). In Botswana, the pathology at the heart of the construct is slightly different, although it still revolves around deviant family relations and over-attachment to welfare aid. My interlocutors, for example, did not specifically emphasize the decline of marriage, but rather the greed of relatives who manipulate dependent individuals to access state resources. This represented a dysfunction at the heart of cultural values of love and kinship, one linked to growing individualism and selfishness (Dahl 2009).

I build these conclusions over the course of the dissertation chapters. I present my chapter findings in a specific order to demonstrate the entanglement of caring ethics with: 1) Tswana conceptions of social personhood and gendered kinship performance, 2) the material precarity of poverty and improvisational survival, 3) the disciplinary gaze of the state, 4) the response of officers as citizens complicate disciplinary regimes, and 5) the replication of social marginalization in the welfare system. The only way to account for these diverse dynamics and tensions surrounding care is to attend to conflictual ethics and debates that attempt to define it. These debates are also ultimately about the nature of the social contract and arrangement of care for the most vulnerable in society.

It is crucial to understand how local systems of meaning and values underlie the empirical ethics of the limits or denial of care, because these tropes do not look the same across all cultural contexts. My analysis suggests that “structural” systems, and the inequalities that they generate, do not emerge as naked expressions of power or malice, but through intimate venues
and valued forms of interpersonal action. For this reason, a social worker may simultaneously seek to protect the vulnerable while also blaming impoverished families for laziness and dependency. In the following section, I summarize how the findings of each chapter contribute to this larger picture.

Chapter Summary

In my introduction, I positioned my research within the broader anthropological scholarship on care. My analysis challenged the public-private binary common to conceptions of care, which naturalizes family care as a realm of inevitable and authentic care. The circulation of care brings actors into relation across domains; in the inverse of case, blockage or denial or care “disconnects” these relations. I challenged the portrayal of care and interdependency as inevitable, and argued that it is a contingent and fraught achievement that must continually be re-produced drawing on a network of relations and resources. The challenges, setbacks, and pervasiveness of poverty that caregivers (and officers) experience in this on-going process set the stage for the “problem of care.”

In Chapter 2, I traced the legacy of Tswana hierarchical and benevolent government from pre-colonial political institutions to the contemporary paternalist developmental state that cares for its vulnerable citizens. I also argued that the growing wealth gap creates tensions between contemporary practices of dependency and historic forms of governance that relied on both hierarchy and benevolent rule. In Chapter 3, I developed my empirical definition of care as the preservation of dignity and social belonging, which exists in the relationship between individuals rather than individual bodies. The achievement of such ideal relations of care required that caregivers seek resources from a range of relations (both kin and governmental). The failure of their relations to provide material resources led caregivers to lament the absence of these relatives and their failure to achieve proper care. This chapter established the relational
framework in which failed claims for material aid create tensions between the ideal of care and the reality of material circumstances.

In Chapter 4, I attended to the central tension that emerged among my interlocutors between ideal expressions of care and the reality of its limitations by reviewing common economic realities and interdependent strategies amongst caregivers. Although such strategies may mitigate the worst aspects of poverty, caregivers experienced challenges with the various obligations that they had to shoulder at once. I established ethnographically how the “problem” of care emerges in the setbacks and frustrations with relations that failed to furnish the distributional flows that define them.

In Chapter 5, I shifted my focus to the interaction of the household caregivers with local representatives of the caring state. I employed the concept of “bureaucratic care” to examine the roles and narratives of actors associated with state offices who distribute crucial resources to households. I used the case study of Community-Home Based Care (CHBC) to illustrate how this form of bureaucratic care targets the relational nexus of care and brings representatives of the state into the domestic domain. This entailed a specific politics and set of disciplinary logics surrounding proper relations. In Chapter 6, I examined the narratives of state agents within the disciplinary logic of bureaucratic care and employed the framework of conflictual ethics to highlight how these framings diverge from those of citizens. This lens revealed a gap between formal logics of dependency and the reality of interdependency in a setting of distributive strategies. I argued that the values of development and modernization exist in tension with long-standing forms of benevolent political hierarchies, so that the distribution of aid is plagued by significant conflicts and anxieties.
In Chapter 7, my final chapter, I explored the implications of the disciplinary apparatus of bureaucratic care in the context of on-going marginalization of Basarwa people in the village. This analysis expanded on the paradox of dependency by analyzing welfare care as a mechanism that replicates the cultural or “ethnic” difference of Basarwa. I argued that bureaucrats act from and affirm a hierarchical relation as they deploy welfare “care” as disciplinary technology, reifying ethnic difference as they attempt to create more disciplined assimilated subjects. The dependency on government aid among Basarwa communities is the continuation of long-standing patronage relations of which “care” is a central aspect, which both preserve and obscure structural relations of inequality.

Throughout the dissertation, I argue it is important to attend to the conflictual ethics of care because this is the basis of debates surrounding the social contract and the arrangement of care for the most vulnerable in society, which has both policy and intimate implications. It is crucial to understand how local histories and values underlie the empirical ethics of the limits of care because these tropes do not look the same across all cultural contexts. They are locally meaningful, even as they are always negotiated and in flux between differently positioned actors. For instance, in Botswana such formulations reflect specific tensions between development values, Tswana ethical personhood, capitalist logics of productivity, and anxieties about the quality of family relations in modern life. My analysis suggests that, as these tensions play out, the inequalities that they generate do not always emerge as the result of naked force or malice, but through intimate venues and valued forms of interpersonal action such as care.

**Relevance and Future Directions**

My research offers some insight into a central quandary that characterizes welfare states: how does the tension between state responsibility to care for the vulnerable alongside the fear of ‘dependency play’ out in concrete circumstances? I employ the framework of conflictual ethics
to show that this process shaped by a range of values, historical legacies, and interpretations of reality by different actors. I propose that the agents of the state and citizens navigate these contradictions between dependency and autonomy as they negotiate “legitimate” need. Conflictual ethics emerge as care (a social value and ideal) is put to various rhetorical ends, to justify appeals for aid as well as approvals and denials of these claims. This analysis reveals that blaming individuals for their circumstances (i.e. poverty and marginality) is a powerful interpretive frame, even among those positioned to help them (state officers and NGO workers). Of course, these individualizing frames, beyond shifting our attention from broader (and more difficult) necessary structural changes, have material consequences for those already living in precarious situations.

It is important to understand the culturally-specific values and dynamics that motivate this framework as it helps us to analyze both the consequences and possibilities of achieving care. It also reveals that the “truths” under which people operate shape what is possible in practice. For instance, the concept of Universal Basic Income (UBI) paid to all citizens is not a new economic concept, but it has not moved beyond exploratory pilot studies in most countries because of the potency of the restricted dependency model (Ferguson 2015). The question of how to distribute resources and care for citizens is relevant in Botswana, not only because of the on-going cost of the nationalized ART program, but also because of growing concerns about future climate conditions and food insecurity.

I was not able to include the data that I collected on food security within the dissertation analysis. This is the next piece of the research that I will develop and analyze. As I discuss in Chapter 3, caregivers repeatedly emphasized the importance of feeding their relative. For this reason, they also often complained specifically about the government food basket; whether being
denied food aid, having it cut off, or finding the subsidy insufficient for the needs of the household. I used the Household Food Insecurity Access Scale (HFIAS), a survey instrument designed to assess if households experienced problems accessing food (self-reported food insecurity) in the previous 30 days. Higher scores indicate more frequent experience of food insecurity in that time frame.

I discovered that 21% of households had a HFIAS score in the top third range, although most households fell in the middle range of occasional food insecurity, only 8% had a 0-score indicating that they never worried about food access. Given that only 32% of caregiving households grew some of their own food in 2014-2015 due to constraints including insufficient land, labor, or money for machinery and seeds, more work must be done to find means to make subsistence more accessible for impoverished families. This data will also allow me to investigate the relationship of food aid to other risk factors, and determine whether those with government aid have lower scores overall. I plan to use the HFIAS score as the dependent variable in regression analyses with variables including household employment, demographics, and usage of aid. I seek to connect issues of food security to the ethics and distribution of care.

How we treat the poor is a global issue. In many parts of the world, including in the US, the dignity and well-being of the poor is under attack, a process that is further compounded when the poor are different or “other.” This research has revealed the difficulty of addressing poverty through the provision of bureaucratic care within a society that is already unequal. Care does not inherently address the structural sources of poverty, marginalization, or difference. For this reason, I want to examine grassroots and local responses that build from organic forms of interdependence and mutual aid already employed by the poor. Community associations are a relatively common formation in Botswana. There was a proliferation of funeral societies in the
wake of the HIV epidemic to help pay for burials, and these remain common in many parts of the village. I plan to work with associations that pool resources and address other social issues, like ART adherence, family counselling, and integration of marginalized people into the community. I am curious about how to scale up these localized responses to organize care and mitigate of poverty and inequality. I would like to examine possible institutional barriers that help or hinder these grassroots strategies. My primary questions focus on the ethical and material dimensions of mutual aid in the associations: Are they less reliant on disciplinary modes of bureaucratic care? Do they produce a different politics of difference and hierarchy? Are they responsive to expanded definitions of dependency and distributional logics?

A primary outcome of this research has been to demonstrate that agents of the state have significant impact on how the programs work and whom they reach. The local safety net is shaped by the people who constitute it, and even a seemingly universal value like care does not unite the perspectives of all these actors. Yet more can be done for those trying to provide ongoing care for their relations. Responses must be designed around new approaches like basic income and pooling communal resources. The paradox of failed care emerges as citizens and bureaucrats differ on understandings of necessary dependency, who is deserving of care, and how to administer it. State apparatuses must value the interdependency, creativity, and flexibility of household survival as necessary for care, rather than hindering it. It is time to disentangle concepts of productive labor and dependency and to legitimize and support diverse forms of labor necessary for an interdependent and integrated social organization of care.
References


