What about the elderly?
A qualitative study about the social situation for elderly women who take care of a family member because of consequences of the HIV/AIDS epidemic in Windhoek, Namibia.

Vem bryr sig om de äldre?
En kvalitativ studie om den sociala situationen för äldre kvinnor som tar hand om en familjemedlem på grund av konsekvenserna av HIV/AIDS epidemin i Windhoek, Namibia.

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Nyckelord: Namibia, HIV/AIDS, äldre, familj, omsorgsgivare.
Abstract
The study aims to create interest and raise awareness in the social field that focuses on elderly and their everyday lives in Windhoek, Namibia. Previous research on HIV/AIDS has primarily focused on people living with the disease or the younger generation and little attention has been given to the older generation. The purpose with the thesis was to describe the social situation for elderly women who take care of a family member because of consequences of the HIV/AIDS epidemic in Windhoek, Namibia. To highlight this topic we have conducted a field study during a nine week period where we interviewed five elderly women about their daily lives and experiences of HIV/AIDS. The method is qualitative and has a hermeneutic approach. To interpret collected data an intersectional perspective has been used to assume the concepts of gender, class and ethnicity. Based on this, we wanted to highlight how power structures interact to create superiority and inferiority in society. The results show that the elderly women we interviewed are experiencing an economic and social vulnerability. Their already strained situation becomes more difficult because of the care provider role. The women expressed that they experience a loneliness and social exclusion from society because of the stigma that surrounds HIV/AIDS. The women do not focus on themselves but prioritize the family and the care takers needs before their own.

Keywords: Namibia, HIV/AIDS, elderly, family, care provider.
Resumé

Denna studie syftar till att beskriva den sociala situationen för äldre kvinnor som tar hand om en familjemedlem på grund av konsekvenserna av HIV/AIDS epidemin i Windhoek, Namibia. Vi har benämnt de äldre som omsorgsgivare (care providers) och dem de tar hand om som omsorgstagare (care takers). Termen omsorgstagare innefattar dem som inte själva kan sörja för sina egna behov, vilket kan vara både föräldralösa barn eller personer som lever med HIV/AIDS. Vi valde att fokusera vår studie på den äldre generationen då vi uppfattar att de har fått lite uppmärksamhet i tidigare diskussioner som rör HIV/AIDS. När vi sökte information upptäckte vi att de var svårt att hitta aktuella fakta och forskning om de äldres situation i Namibia, vilket gjorde att vi ville ta reda på mer om ämnet. Vi valde att utföra en studie med syftet att belysa den äldre generationens vardagliga situation i rollen av att vara omsorgsgivare.


I vår redovisning av det aktuella forskningsläget redovisar vi hur Namibias sociala skyddsmätt främst är baserat på att familjen ska ta hand om dem som inte kan klara sig själva. Det innefattar grupper såsom sjuka, äldre eller barn som förlorat sina föräldrar. Den forskning vi utgår ifrån visar att den äldre generationen i större utsträckning än den yngre generationen tar sig an rollen som omsorgsgivare. I Namibia är det vidare så att det är kvinnor som i största utsträckningen är de som tar hand om HIV-sjuka och barn som förlorat sina föräldrar i sjukdomen. Vidare att omsorgsgivarrollen innebär ett psykiskt och fysiskt tungt arbete som kan leda till stigmatisering när det är sammankopplat med HIV/AIDS.

Det framgår även från redovisningen av forskningsläget att denna omsorgsgivarroll inte alltid sker under ett frivilligt åtagande utan en känsla av tvång. Vidare i forskningsläget uppmärksammas att de som tar hand om någon på grund av HIV/AIDS ofta utsätts för stigmatisering på grund av deras koppling till sjukdomen.

Fältstudien är utförd i Windhoek, Namibia, en nio veckors period under hösten 2012. Studien är kvalitativ och består av intervjuer med fem kvinnor i åldrarna 57-75 år som lever som äldre omsorgsgivare. Vi sökte personer över 60 år då det är pensionsåldern i Namibia, men lämnade utrymme för några års marginal vilket gjorde att vår yngsta respondent är 57 år. Intervjuerna vi utförde var semistrukturerade och vi utgick från olika huvudfrågor där sedan intervjupersonerna hade möjlighet att berätta sin historia öppet och med egna ord. I enighet med syftet för en kvalitativ studie så försökte vi söka en djupare förståelse i berättelsen som våra respondenter gav oss. Under intervjuutthållena och när vi lyssnade igenom det inspelade materialet efteråt försökte vi urskilja olika teman i kvinnornas berättelse. Utifrån dessa teman
har vi sedan valt ut olika citat som vi anser speglar essensen i den information som kvinnorna delgav oss.


Inför studien var det nödvändigt att göra olika etiska överväganden. Respondenterna informerades om det svenska etiska vetenskapsrådets rekommendationer inom forskning och vilka rättigheter de hade under intervjuuttömmingen. Den svenska etiken överensstämmer inte alltid med de normer som råder i landet och det var vi tvungna att ta hänsyn till det. De kvinnliga informanter hade själva som krav att deras rätta identiteter skulle speglas i vår studie, då de upplever att de berättar sin livshistoria och vill vara med och påverka. För att kunna få en medelväg med det etiska rådet och våra informanter har vi valt att enbart presentera kvinnorna vid deras rätta förmann.


Diskussionsdelen i uppsatsen berör positiv och negativ kritik gentemot använd metod och resultat. Vi ger även förslag på fortsatt forskning inom området.
Foreword

It is difficult to describe in words what our field study in Namibia has meant to us. It has been an incredible journey and a huge and invaluable experience for us. Conducting a study abroad, also in a developing country, was a contrast to the reality that we are accustomed to. To be invited and welcomed into people's everyday lives and be able to take part of their everyday experiences was for us a great honour. The people we met and their story is something that we will carry with us for the rest of our lives.

We would like to dedicate our gratitude to the people who made this journey and bachelor thesis possible. First and foremost we want to thank Sida that through their scholarship gave us the economic resources to enable our travel to Namibia. We want to thank NANASO and Catholic AIDS Action for their dedication and willingness to help us in the quest to find respondents. We also want to thank our mentor Lars Bergström who contributed with many wise words and shared his knowledge of both Namibia and the academic world, and also provided us with invaluable guidance in the work with our thesis. We want to give a special thanks to our contact person in the field, Victoria Schimming that through enthusiasm, humour and inside knowledge welcomed and introduced us to Namibia and its culture. Vicky was also a gate opener to all the contacts we gained in the country and we would not have gone far without her.

We also want to give our last and greatest thanks to all strong and loving women who participated in this study.

We hereby declare that Isabell Persson and Elin Trygg commonly implemented all parts of the thesis.

Karlstad 2013
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1. Introduction

“When I was a young lady like you and you, I was having a good and healthy life. But since my kids, the son and the daughter passed away, then it changes. Then it becomes difficult. I can only tell you that my life, the time I was happy was when I was young. And now, I can tell you, if I have to tell you, I am not having a happy life. Though I am happy to have grandchildren, to have kids, but the daily activities, and the daily expenses and the needs, no no…” (Johanna).

1.1 Problem specification
The HIV/AIDS epidemic has received significant media coverage, improving the knowledge base of our global society. However, our understanding is that earlier research on HIV/AIDS has mainly focused on the infected and the young people, with little attention given to older demographics. We want to draw attention to the elderly and explore how their lives are affected by HIV/AIDS epidemic.

In recent times the status of the elderly has become an important topic in developing countries since improvements in health care of increased global life expectancy. Additionally, conflicts arise between local customs over who should provide care (Carleson 2011). Namibia is a developing country, that has experienced good economic growth. Even so, the country has major social problems, about a fifth of the population is infected with HIV/AIDS. Most people who develop AIDS are adults with families whose lives also are affected and changed as the disease progresses. This means that the disease affects far more than those who themselves are living with the disease (Sida 2010). Current research shows that those diagnosed with AIDS live longer due to antiretroviral drug treatment which leads to extended need of care and a resulting increase in care providers. Moreover, the elderly are those who increasingly have to take care of the sick and who become responsible for the surviving children. This places new demands on the elderly and their ageing bodies, when they give care while they in fact may need help and care themselves (Thomas 2006; de Klerk 2011). A current problem within social work in developing countries is managing the new group of elderly and their changing needs in areas such as welfare, health, care and pension (Carleson 2011).

Why is it important to shed light on how the elderly generation is affected by HIV/AIDS? We believe that adequate information is both missing and necessary. It requires knowledge on how the elderly’s situation appears, so that adequate resources can be directed where they are most needed. We want to inspire to further research so that actions between government and the voluntary sector can complement each other and both service providers can be efficient with their respective resources. According to Foster (2004) the traditional safety net in the form of family is about to change. Therefore we believe that great effort and support in the social field will be required to provide safety nets for vulnerable individuals, suffering from both the primary and secondary effects of HIV/AIDS epidemic.

1.2 Purpose
The purpose with the thesis was to describe the social situation for elderly women who take care of a family member because of consequences of the HIV/AIDS epidemic in Windhoek, Namibia.
1.3 Question at issue
How is the elderly generations’ daily life affected by the HIV/AIDS epidemic in the role of a care provider in Windhoek, Namibia?

1.4 Central concepts
1.4.1 Care provider
Being a care provider means to take care of someone physically, psychosocially or emotionally. Care providers can be family members, relatives or someone who is connected to a Non-Governmental Organisation (NGO) or the government (Campbell & MacMillan 2012). In this thesis the term care provider are used when referring to elderly who take care of someone in their family because of HIV/AIDS.

1.4.2 Care taker
Care takers are the individuals whom the care providers take care of, most of the time this means people living with HIV/AIDS or other terminal diseases. Orphans and vulnerable children can also be included under the term care taker (Campbell & MacMillan 2012). In this thesis the term refers to those living with HIV or children who lost their parents in HIV/AIDS and receive help from a care provider.

1.4.3 Family
In this thesis the concept of family involves all social contacts that the respondents refer to as their family. This can be both the biological nuclear family, extended family as well as other people that the respondents call family outside blood band within or outside the household. (More information under the section 3.1 Family structure, page 9.)

1.4.4 HIV/AIDS
The HIV virus, human immunodeficiency virus, causes AIDS, acquired immune deficiency syndrome. The virus is passed from one person to another through blood and/or sexual contact. Pregnant women who carry the infection can pass it on to their child. HIV belongs to a group of viruses known as lent viruses (the Latin lentus, slow) and the majority of HIV infected develops AIDS as a result of the HIV infection. HIV attacks the white blood cells in the body that serves to defend the body against infections. An HIV positive person’s immune system is over time destroyed and as a result suffers from life-threatening infections that a healthy person’s immune system would have coped. When the disease entered this phase it is called AIDS (UNAIDS 2008).

1.4.5 Stigmatisation
Goffman (2011) talks about what is considered a deviant, what distinguishes an abnormal behavior and how society responds to this. He describes three categories of so called stigmatising (stigma): physically, mentally and socially. Goffman argues that when an individual is included in any of these stigmas and meet a person who by the society is classified as a normal individual will be assigned certain characteristics that make him/her not fit into the context of "normality" and therefore marked and thus stigmatised by society (Goffman 2011).
1.5 Disposition

The thesis will begin with an introduction, in which the case study is outlined: elderly women who are providing care for those affected by the consequences of HIV/AIDS. Then the purpose and question at issue are described, specifically, how is the elderly generation daily life affected by the HIV/AIDS epidemic in the role of a care provider. After that a background of the topic is provided that includes information on the current situation in Namibia; the effectiveness of existing institutions such as the legal system, social safety and HIV/AIDS. Then the literature study is presented, it consists of information about the family structure and current research. The literature review is followed by a description of the thesis theoretical framework that consists of an intersectional perspective with a focus on gender, class and ethnicity. Then the method that was used during the study is presented. Following this is a description of the result and analysis of our field study. The conclusions are summarized in a final discussion section where critiques of the results are presented.
2. Background

To provide an understanding of our field of research, we will first present an overall background information about Namibia.

2.1 History Namibia

Outsiders, people who are not from Africa, are not familiar with all aspects of the early African history since it has been transmitted orally and remained within the continent. The first people of Southern Africa are considered the San and nomadic people have for thousands of years lived in the area of current Namibia. During the 14th century Bantu people began to immigrate and later more and more groups of people came to the area (Ejikeme 2011).

Europeans began to settle Namibia in the 19th century. From 1884 until World War One, Namibia was a German colony formerly known as German South-West Africa. For many years, the Germans brought a policy of racial segregation and deprived the indigenous population of their rights. In 1904 the Herero people rebelled against the German regime and war began between the indigenous Herero’s and the Germans. During that year the Germans issued an extermination order that all Herero men, women and children would be executed. It resulted in the first genocide to take place in the 21st century, a tragedy that came to be known as the first genocide in modern times (Ejikeme 2011).

After World War One the country was placed under rule of South Africa and the protection of League of Nations, the precursor to the modern United Nations. Following the collapse of the League of Nations, mandate countries such as South West Africa were handed over to the United Nations, with the purpose of eventually granting their independence. However, South Africa refused to hand over the country preferring to administer it as its fifth province, and institution the racial based system of apartheid. Apartheid was a social system that legally controlled racial segregation to the advantage of the white minority. The apartheid system ended in 1990, when the country gained its independence from South Africa. The first democratically elected government was led by the South West Africa People’s Organization, the main liberation group that led the resistance against apartheid (Ejikeme 2011).

2.1.1 Windhoek

Windhoek is the capital of Namibia. During apartheid, Windhoek was divided in three different areas: the city was only for white people, Khomasdal was set aside for the coloured population, while leaving Katutura for the black population. The name Katutura means "A place where we do not want to reside" (Ejikeme 2011:18). Today more than 200,000 people of Windhoek's total population of 300,000 live in Katutura and the majority is still black even though the area is becoming more multi-ethnic (Ejikeme 2011).

2.2 Overall facts about Namibia

Namibia is a country in the south-western part of Africa and has a population of about 2.1 million people over an area of about 825,000 square kilometers. Namibia is a republic with a multiparty democracy and the ruling party is SWAPO, with President Hifikepunye Pohamba as the current leader of the country. Some argue that the regime is becoming increasingly authoritarian, and democracy is beginning to resemble a one-party system. SWAPO routinely sweeps regional elections, and in national elections regularly receives more than 60 percent of the vote (Sims & Koep 2012). Namibia is a middle income country and the economy consists primarily of income from its supply of minerals (mostly diamonds and uranium), fish and
livestock (Ejikeme 2011). Import goods mainly consist of consumer products, petroleum and machines (Central Intelligence Agency [CIA] 2012). The historical link between Namibia and South Africa means their economies are quite intertwined, and for this reason Namibia has chosen to tie their currency to the South African Rand, meaning the currencies are worth the same in Namibia (Ejikeme 2011).

Namibia consists of a wide variety of people with different cultures and languages. English is the official language, while Oshiwambo is the language most people use (about 50 percent). Other languages in the country include Afrikaans, Damara/Nama, RuKwangali and Otjiherero (between eight and eleven percent of the population speak these languages). There are also a number of minority languages such as Khoisan and German. It is common for people to speak more than one language, making Afrikaans a bridge language between different Namibians (Government of Namibia [GOV] 2011a). Most of the population is black, while six to seven percent is coloured or white (CIA 2012).

The majority of the population lives in rural areas while about 40 percent live in urban areas, mainly in and around the capital Windhoek. Namibia has an age distribution, which has a relatively high dependency rate, 36 percent of the population is between zero to fourteen years and those above 60 years represent between five to six percent of the population (United Nations Statistic Division [UNSD] 2009). Life expectancy in the country is approximately 52 years (CIA 2012), this is reflective of the high HIV/AIDS rate, which naturally lowers the country's life expectancy. The country's official religion is Christianity, with roughly 90 percent of the population identifying as Christians; half of them Lutherans. Besides Christianity, parts of the population are influenced of African tradition through for instance faith in the supernatural (Ejikeme 2011).

Namibia is considered one of Africa’s most democratic countries in southern Africa and its constitution ensures basic human rights and equality. Even so, Namibia is one of the most unequal societies in the world, having a GINI coefficient of 0.7 (GINI coefficient measure income inequality, 1 means that one person has all of the resources while 0 means the country is completely equal). Poverty is concentrated in the countryside (Sims & Koep 2012). The richest ten percent of the population earns over half of the country's Gross Domestic Product (GDP) and approximately 56 percent lives below the poverty line of less than 2 dollars a day (CIA 2012).

Lack of job opportunities is a major problem in the country and according to the World Bank (Sims and Koep 2012) in 2011 an estimated 40 percent was unemployed, though this statistic is quite similar to unemployment rates throughout the region (South Africa has an official unemployment rate of 25 percent, though many argue the true number could be double that, and Botswana has an unemployment rate of 40 percent). Unemployment figures in the region are notoriously difficult to measure, because of the relative size of the informal economy, making it difficult to count those who are truly unemployed and in need of states assistance, versus those who have jobs within the informal sector. In Namibia a person is considered to be unemployed if they have not been employed for at least one hour during the prior week (Sims & Koep 2012).

Approximately 90 percent of the population is literate, and the expected length of school is 12 years (CIA 2012). The country has one university, the University of Namibia, and there are also several occupational colleges. Freedom of press and speech is guaranteed by law and is accomplished fairly well. Even though Namibia has an extensive legal framework that assures
equality some groups are still excluded, for example is homosexuality not permitted under Namibian law (Landguiden 2011).

2.3 Legal system

The Namibian Constitution makes it clear that all persons are equal before the law and that no person shall be discriminated on grounds of sex, race, colour, ethnicity, religion, creed, social or economic status (Legal Assistance Centre [LAC] 2010). Namibia has five different types of laws: The Constitution, Statute Law, Common Law, Customary Law and Court Decisions. The Constitution Law is the basis of the country's legal system. Customary laws differ largely from the other laws as they are enacted and practiced only on a local level. They are legally valid as long as they do not violate the Constitution. Customary laws exist in communities and are based on the culture and customs that prevail in those communities. These laws are considered valid if they are known in the community and are for the most part not written down. Penalties can be issued to those who violate Customary law (LAC 2009).

2.3.1 Law and gender equality

The Namibian Constitution guarantees men and women equal rights in general, within and outside marriage and inheritance. Even though the Constitution establishes gender equality, women in reality have a weaker position in society than men. Women's low status affects HIV prevalence in the country in general, because they do not have the same capabilities to make decisions about their body, their sexual contacts, or how they protect themselves during sexual intercourse. For example, instances of men using their position of power over women to force them to give sexual services in exchange for protection and financial security is quite prevalent (Republic of Namibia 2007).

Customary Law is based on the ancient African tradition, which means that many laws are preserving old customs but these laws can also be codify gender discriminative. For example, the Customary Law is based on a tradition that the husband should be the head of the household. Customary Law is as mentioned valid as long as it does not contradict the Constitution, but there are laws that have other sources of origin. Polygamy, for example, is illegal under Civil Law but not established in the Constitution and therefore is accepted under some Customary Laws. This means that men can take on several female partners. Multiple concurrent sexual partners is a major cause of the spread of HIV/AIDS, and having more than one wife contributes to the spread of the virus (LaFont & Hubbard 2007).

2.4 Social safety

2.4.1 Family

Namibia's social safety net is weak, requiring the family of marginalized individuals to take responsibility for their vulnerable kin. The majority of the Namibian population live in traditional households while only two percent of the population lives within institutions (such as hospitals, retirement homes, etcetera) or within specific population groups (classified as for example homeless, travellers and others) (GOV 2011b).

By Namibian law, parents are required to take care of their children. If the parents pass away, or for other reasons cannot take care of their child, a new care provider must be appointed. This responsibility transfers to the child's grandparents first, and then the great-grandparents etcetera. If the grandparents are not alive or for some reason cannot take care of the children, other relatives take over the parenting (not in-laws). Even children, when they are adults, have obligations to their parents. If the children are not alive the responsibility goes on to the
grandchildren or great-grandchildren. If there are no close relatives the responsibility goes to the extended family. For example, if an elderly person is in need of help, their biological children have a legal duty to help them. If someone in the family is in need of help, for example economically, the rest of the family have to help out if they have the resources. It can become a legal action if they fail to fulfil their duty as providers (LAC 2005).

2.4.2 Maintenance
Namibia has a certain social safety net in the form of maintenance. The Namibian government offers three types of social funds for people in vulnerable groups: child maintenance grant, old age pensions and disability grants. Maintenance varies to some extent in the country because of Customary Law (LAC 2005).

The first group concerns parents who need financial help to take care of their children. The criteria for receiving child maintenance are that the child must be under the age of 18 and attend school if they are of school age. The income of the household may not exceed 500 Namibian Dollar per month (LAC 2005). 500 Namibian Dollar is equivalent to about 45 EURO (Valutomvandlaren 2012). Parents can apply for child maintenance grant and also people taking care of a child in the parent's place. Child maintenance can be given to a maximum of three children per household. From application to disbursement three months are expected (LAC 2005).

Namibian citizens reach retirement at an age of 60 years and after that they can receive a pension every month. Old age pensions are paid to citizens over 60 years who applies for it. Disability grants are given to people over the age of 16 years that because of disability need financial help. HIV/AIDS positive are not covered under the designation disabled (LAC 2005).

2.4.3 Community Home Based Care providers
Besides the family, volunteers make a great effort for the people who are in need of help in Namibia. The so-called Community Home Based Care Providers (CHBCPs) perform help in the home for those who cannot reach support through other means, such as elderly, sick or vulnerable children. In 2007, there were about 20 000 registered CHBCPs in Namibia, they can be registered with both NGOs or the government. The documentation on the help provided in the home is inadequate, but the support focuses on a wide range of activities including: education, counselling or direct care (Bautista 2012).

Many of the NGOs in Namibia get a large part of its resources from international NGOs. From the year 2010, Namibia is classified as an "upper-middle-income" developing country. This resulted in reduced international aid to Namibia. Namibia is now expected to have less need of assistance from other countries since it is considered relatively rich. International assistance to the country has decreased thus reducing the domestic NGO resources and their capability to help their constituents (Bautista 2012).

2.5 Consequences of HIV/AIDS
The HIV/AIDS expansion in Namibia is among the highest in the world (Ejikeme 2011). The HIV/AIDS infection is a persistent engrossing health problem in Namibia and around 18 percent of the adult population is infected with HIV/AIDS. Official statistics on HIV/AIDS prevalence in the country are developed mainly by testing pregnant women during early scheduled check-ups (LAC 2009). The prevalence varies between different parts of the
country and due to incomplete statistics it is impossible to get accurate data on prevalence rates (Ejikeme 2011). The government has and is investing heavily in HIV/AIDS prevention and treatment, as today 90 percent of the infected population has access to antiretroviral treatment. However, delivery of primary health care is hampered by financial constraints (Sims & Koep 2012). In Namibia there is a private and a public healthcare sector. Only a small percentage of the population can afford private help (Bautista 2012).

Despite the high prevalence of HIV/AIDS in Namibia, the stigmatisation of the virus has made it difficult to create an atmosphere for frank and honest discussion. Those infected face alienation from their communities and their whole family is affected. The HIV-positive become excluded by society and sometimes even from their family, because the family does not want to be affected by the discrimination and stigma that accompanies the disease. In other cases people that have an infected family member attempt to conceal the disease or exclude the HIV-positive from the family (LAC 2009).

The fear of being affected by HIV makes people choose not to get tested, and due to this there is substantial number of unrecorded cases and many Namibians, themselves do not know they carry HIV. Prejudices about how to get the disease also leads people to believe they cannot get infected, for example, some believe that the disease only affects homosexuals. Lack of trust of the confidentiality and expensive antiretroviral drugs within health care is also a reason that people avoid getting tested for the disease (LAC 2009).

Namibians tend to view the virus as something degrading and often times those who have HIV/AIDS will keep their status private, telling very few people. Apart from the actual course of the disease HIV/AIDS can pose serious consequences for the individual if his illness becomes known to the public. To suffer from HIV/AIDS could mean that the person has difficulty keeping his job or problems gaining new employment, making their financial situation difficult to manage. Violence and other forms of victimization are also common for the HIV-infected population. The Namibian law does not address the HIV/AIDS positive individuals directly, but they are protected by the Constitution. People living with HIV are protected by the general rules, for example the law of equality. Otherwise, HIV/AIDS is not classed as a disability or covered by discrimination laws (LAC 2009).

Women are expected to be more effective in taking care of sick relatives, while also handling the home and everyday tasks. This division of chores applies even if the women themselves are living with HIV. Women comprise most of the population of care providers in Namibia, although the number of men is slowly increasing (Campbell & MacMillan 2012).

A survey conducted by Volunteers over coming Poverty and the WHO (World Health Organisation) in Namibia, as well as six other African countries show that about 80 percent of HIV-positive receive the support and care they need at home. Of people who receive help, about 90 percent of them get it from women or girls and only a small percent from men. This results in many of the girls being forced to leave school in order to care for the sick (Volunteers overcoming poverty [VSO] 2012). Women resigning from their jobs in order to take care of the ill are not uncommon in African countries such as Namibia (Campbell & MacMillan 2012).
3. Research position

To give an understanding of the reality that the elderly in Namibia live in, this section will present the family system and culture that prevails in the country. Since no previous studies focus on elderly women as care providers previous research that is close to the purpose of this study has been used. Below, current research is presented, that in different ways reached conclusions about kinship relationships, the care provider role and HIV/AIDS in Africa.

3.1 Family structure

Family sociology has its seat in the family, their relationships, such as the relations between children and adults, the children themselves, or how parents interact with each other and the family in general. Family sociology focuses on families versus society and the relationship to related and unrelated families. Family sociology also tries to specify the meaning of "family" and focuses simultaneously on comprehending the different sets of families for example: multi-family households, step-families and single-parent households (Trost 2012). Family sociology will not be used as a theoretical framework in this thesis. It is presented to give an understanding of what families are and the variation it can involve.

We explain the Namibian family through Foster’s (2004) definition of African family structure. Foster (2004) describes the societies in African cultures and distinguishes the concepts of household and the concept of family and discuss the differences between them. The concept of household is aimed at a group of people who are economically and socially dependent of each other and live together. Unlike the household concept, the family concept includes a wider range of people, even relatives living outside the household. Foster (2004) uses the term extended family which means that the family not only consists of the biological family but can extend beyond the nuclear family. It includes multiple generations and elongated relationships with others and also results in specific ethical requirements towards each other. For example the extended family involves rights and obligations in terms of social and economic support (Foster 2004). When we use the term family we include social contacts that our respondent refers as their family. This can be both the biological nuclear family, extended family as well as other people that our respondents call family outside blood band within or outside the household.

In Africa, the social safety net mainly consists of the family. Although many children have lost their parents to the HIV/AIDS epidemic they have not been without a guardian because they have been taken care of by relatives, the extended family (Foster 2004). Public foster care exists in Namibia, but this form of kinship care is more common and occurs unofficially without government interference (Ministry of Gender and equality and child welfare [MGECW] 2010). Orphaned children are primarily cared for by aunts and uncles, but it has become increasingly common with grandparents or other relatives taking over.

This traditional system is however disappearing due to changes in Africa, people move into cities to obtain jobs and education and their will and ability decreases to care for orphaned children or other relatives who need help. Costs for schools and health care are also contributing factors to why the extended family has less ability to care for additional family members (Foster 2004).

3.1.1 Ubuntu

Ubuntu is a kind of African philosophy that explains how humans are connected and shares a common world together. It is something that binds people together despite different cultures,
religious beliefs or communities. Ubuntu describes people’s common belief in a link between living people and their ancestors. It also involves rights and obligations towards each other and other people’s well-being (Sonal n.d.). Ubuntu is about existing in a community with others; it revolves around a mutual respect for other people and to share and stand equal with others (Karenza 2010).

3.2 Being old in times of AIDS
Josien de Klerk (2011) writes in the dissertation "Being old in times of Aids - aging, caring and relating in north-western Tanzania" about how older women and men are affected by the HIV/AIDS mortality in Tanzania. The dissertation is based in Tanzania while our research focuses on Namibia. We believe that the topic also concerns current Namibia and that the research undertaken in Tanzania can be related to the situation in Namibia. It is nevertheless important to point out that the two countries also differ in some relevant areas. Tanzania has a larger population, 44 million compared to Namibia’s about 2 million, they have about the same proportion of people over 60 in the population and Tanzania has a lower HIV prevalence than Namibia (approximately 5.6 percent). Tanzania has a higher proportion of the population living in extreme poverty, about 70 percent compared to Namibia’s about 50 percent. Tanzania also has a larger proportion of the population living in rural areas (Globalis 2012).

de Klerk (2011) puts the older generation in context, regarding the HIV/AIDS infection. The author believes that Africa has failed to see older people's situation as care providers and how kinship relations have changed over time. The purpose of the dissertation is to gain a deeper understanding of older people in the country and the experiences and feelings that arise with being old during times of AIDS. The author especially focuses on care relationships and how it changes over time when conditions change.

de Klerk (2011) uses kinship theory as her theoretical basis. She explores relationships and the nature of care in order to understand how they are formed between generations and by the circumstances. The author clarifies what she means by the concept of care and aims to material, emotional and practical help. It applies to those who cannot meet their needs themselves for example children, elderly or ill people. de Klerk (2011) also describes that care is a process that changes the relationship over time and that care becomes an identity formation as it can lead to role changes. Care is not exercised independent of the environment, the relationships are affected by other people's perceptions and are created every day. The dissertation is a longitudinally and descriptive study conducted between 2002 and 2005. de Klerk (2011) uses a qualitative approach in the form of interviews to examine how perceptions of AIDS changes over time and in different life stages of people's lives. The respondents consist of a dozen women and men over 60 years of age in a small rural village with 105 households in north-western Tanzania. Data collection consisted of household interviews, everyday conversations and notes about daily events.

The author describes how older people receive increasing number of care tasks while at the same time it is more difficult for them to perform these tasks because of their growing age. de Klerk (2011) expresses the emergence of a new social field which has occurred because of the different care conditions for HIV/AIDS infected. The older people have to adapt to the circumstances of prolonged care of patients, grief, raising surviving grandchildren and loss of their own old age security. de Klerk (2011) describes the vulnerable situation of the older generation when they, for example, must take care of their sick adult children while they also
must assume the parental role for their grandchildren.

dé Klerk (2011) describes how kinship relationships are strengthened, and that new kinship relationships constantly are created during the AIDS era, so-called "doing kinship". The elderly, who live now are the last generation that grew up during the period before AIDS and the experience of the elderly differs clearly in the time before and after that AIDS infection. The author expresses that AIDS has changed the conditions for the elderly and shaped gender and generational roles and values about care and also affected older people's economic conditions. The author describes how three decades of HIV/AIDS has affected the population and the care and kinship patterns in the villages of Tanzania and how the older generations have to constantly adapt to new circumstances and responsibilities.

dé Klerk (2011) explain how the elderly become more aware of their aging bodies and that the elderly feel that they are dependent on their bodies and their physical strength to cope with their survival. Providing care is physically and emotionally heavy, it is also time and resource intensive. The elderly see their bodies as a prerequisite to survive and remain independent. It creates a concern about the future and what a normal aging with reduced strength may entail for them and their family. Since antiretroviral drug treatment came, life expectancy has increased.

3.3 Parenting at old age
Lars Bergström\(^1\) introduces the concept of second parenthood. The term aims to describe how the elderly become parents again when they become responsible for children who lost their parents through death or other causes. In Africa, it is common that someone other than the biological parents care for and raise a child, but second parenthood intends to describe more of an enforced parenting that occurs when the biological parents for various reasons disappear from the child's life.

3.4 Stigma, fatigue and social breakdown
The following survey was conducted in Namibia's rural areas, opposed to our field study that takes place in the capital city, Windhoek. It is important to note that the Caprivi region differs slightly from Namibia in general, for example the Caprivi region is the area with the highest HIV prevalence in the country. Surveys show that HIV prevalence in the region is around 40 percent. Otherwise, the percentage of elderly in the area consistent with the age composition in the country in general (Ministry of Education, HIV and AIDS Management Unit 2010).

Felicity Thomas (2006) has in the scientific article “Stigma, fatigue and social breakdown: Exploring the impacts of HIV/AIDS on patient and carer well-being in the Caprivi Region, Namibia” introduced the relationship between care providers and care takers in relation to the HIV/AIDS infection. The article is for the most part conducted through an examination of diaries written by seven HIV infected and their carers over a period of between one to seven months.

Felicity Thomas' (2006) article focuses on the patients and their care providers and what impact the HIV/AIDS infection has on the household and the stigma that the disease brings. HIV/AIDS infection gives according to Thomas (2006) major impacts on the patients and

\(^1\)Lars Bergström, lecturer, Karlstad University, 2012-03-12
their carers, consequences in terms of lower self-esteem, emotional and social difficulties, while the mental and physical health is strongly affected. There are also consequences that extend beyond the physical such as social exclusion, ostracism, isolation of the sick and its surroundings.

Thomas (2006) has with her research found that the HIV/AIDS infected and their care providers, in addition to stigma and the physical strains, also forces to be aware of the fact that people tend to forget the individual behind the disease. Instead of seeing an individual with a disease they only see a sick individual.

Thomas (2006) argues that previous research only focuses on those infected with HIV/AIDS and how they feel about their lives. The author now intends to lift the stigma that is associated with the HIV infection both for the care provider and the care taker. She also points out that previous research is conducted in large cities where the stigma of the HIV infection not is as widespread, and aims now to research and examine how stigma affects the HIV infected in rural areas such as the Caprivi region. Thomas (2006) emphasizes the importance of research on a local level to address the problem around stigma, and are taking initiatives around new ways to help, thus reducing the burden for the care providers. Much of the care is provided in the home and therefore it is important to focus on improving the opportunities to care for the sick at home.

3.5 Child fostering

This study takes place among the Ovambo families in Namibia. There are differences between different ethnic groups in Namibia in terms of tradition and culture (Ejikeme 2011). Therefore, there may be differences in how child fostering function among other families in the country and among the people that was interviewed in the study.

Brown (2011) has in her scientific article “Child Fostering Chains Among Ovambo Families in Namibia, Southern Africa” conducted a qualitative survey among four Ovambo families in Namibia and studied their relation to child care. The study intends to examine kinship relationships and the fostering of children, both biological, orphans and fostered children. The author intends with her research in the long term help contribute to better care for the orphaned children in southern Africa.

Brown (2011) speaks of the current elderly generation as those who increasingly seem to care for their relatives. The HIV/AIDS epidemic has a strong impact on the care giving and the researcher predicts that the next future generation of elderly can come to be depleted by HIV epidemic. Brown (2011) also means that the woman is the ones who pull the biggest load as care providers in the HIV epidemic. The study shows that the families who care for an orphan child on grounds of HIV/AIDS have a greater tendency for fragility than families who do not take care of an orphaned child, but also point out that the adaptability of these families is fascinating and that they should not be underestimated.

Brown (2011) estimates in her study that about 12 million children have lost their parents to HIV/AIDS related causes in Africa so far. Brown (2011) argues that there are four different types of care for children who lost their parents to the HIV/AIDS epidemic in Namibia. Care in the close family, care giving of people around the child, for example the neighbours or friends of the family (designed to make the children be in a familiar environment) care through NGO’s or other organizations that work with children. The fourth alternative is
institutions such as orphanages. This last alternative is not something that is accepted in society, and serves as a last resort, when there is no one else that can take of the child.

Brown (2011) defines the term "orphaned" when she refers to a child who lost a parent in the HIV/AIDS epidemic. In Namibia, it is common to care for their siblings' children or other relatives children, the Oshivambo call this for oluteka, which means to mother somebody else children in their place.

Brown (2011) speaks of the maternal grandmother as a priming part of child-rearing in Oshivambo families. It was found that if a younger member example daughter of an elderly felt that the elderly would take care of the grandchild the elderly more or less felt forced to take on this new parenting/caring role.

The author argues that continued research within family networks in Namibia must be made within, outside and between households. She argues that the family is not only the residents within the household, but the family may also extend beyond the household and the family and kinship can change over time.
4. Theoretical framework

Our theoretical framework consists of an intersectional perspective where we assume power structures in the form of: gender, class and ethnicity. We experienced that these three concepts are the most relevant to illustrate our results. Using an intersectional perspective, we will answer our research question: How is the elderly generations’ daily life affected by the HIV/AIDS epidemic in the role of a care provider in Windhoek, Namibia?

4.1 Intersectionality

Intersectionality is a perspective that describes how various social structures form power relations. Intersectionality has its origins in the American anti-racist feminist movement in the 1970’s, called Black Feminism. They expressed that it is not possible to have a unified feminism since material and social conditions of women from different ethnic backgrounds differ. The feminist movement claimed that you can not only use gender to understand the superiority and inferiority in society without take into account aspects such as class and ethnicity (de los Reyes & Muliniari 2005).

Black feminism has evolved into a concept that describes how the white hegemony dominated feminism and concealed the power relations that depend on ethnicity. Intersectionality expresses that there is a hegemonic order in society where the heterosexual, white middle class has been the basis, which has prevented a multifaceted understanding of social structures and oppression. The intersectional perspective shows that gender, class and ethnicity always interact and therefore cannot be understood separately (de los Reyes & Muliniari 2005).

The word intersectionality means intersections between different meeting points of structures in society and demonstrates how the different divisions within the intersections both can work alone and together. Intersectionality is used to explain how different power structures in society create oppression and subordination in society. It for example involves gender, class, ethnicity and sexuality (Mattson 2010).

To understand intersectionality one can imagine various categories of societies power structures. The power structure means groups at macro level where the hierarchical order prevails and some have more influence and power than others, the thing they have in common is that they affect inequality in society. We are affected and also unconsciously affect these power structures through our actions and attitudes. Different categories are more powerful than others in different contexts, for example can class or ethnicity be more relevant than gender in certain situations when to explain how people relate to each other and how power and oppression is created and recreated in our communities. Different power structures may be easier to understand at a societal level where you can compare statistics. Intersectionality should also be understood at an individual level because every individual is a complex result of many different properties. At an individual level it is more difficult to see which category affects what in different contexts since you always see the person and not the categories that you can do when you are dealing with larger numbers (Mattson 2010).

When talking about a group of women or men one have to take into account the differences that exist within the group such as race, ethnicity, sexuality and class. Depending on which class you belong to, you have different experiences of gender, ethnicity, and etcetera. These intersections affects how power and inequality is created in our society and how certain groups of people are excluded and oppressed (Mattson 2010).
4.1.1 Gender
Mark (2007) describes gender as a concept that separates the biological sex from the social or cultural. Different gender theories argue that we attribute men and women with different characteristics depending on their biological sex. It leads to different perceptions, expectations and standards on gender and as a consequence of the power structure that arises (Mark 2007). The term gender comes initially from Latin and means kind, variety, generation and sex. The term gender explains common views on sex and gender implications. The views that we as individuals interpret around sex and gender, produced and reproduced constantly by means of what people say and do and what we are thinking about ourselves and others (Hirdman 2003).

According to Hirdman (2003), we are shaped or categorized into a gender order from the beginning, which dictates what is considered masculine and feminine. At an early age our gender roles begin to develop, which is something out of our control. Women are assigned certain characteristics that result in resulting behaviours and social responsibilities the same goes for males. Traditional gender roles dictate that women spend a disproportionate amount of their time tending to the home and taking care of the domestic chores such as cooking, cleaning and looking after the children. While the males traditionally act as the breadwinner spending much of their time outside the house. These characteristics are explained as something biologically predetermined rather than socially constructed (Hirdman 2003).

Hirdman (2003) argues that the gender order creates a system that consists of a number of cooperating processes that further creates patterns, which permeates everything in our society. These patterns create a basis for the political, economic and social order in the society. Male dominance and female subordination permeates into almost everything, from our thinking to our culture.

Furthermore, one can say that the gender order is based on two different principles. One is based on a dichotomy that ascribes certain characteristics for men and women in pairs of opposites. They were also provided with specific chores and positions, which contribute to the fact that keep the sexes separated. The other principle is based on the male norm. This argues that the male is the main provider for the woman while the latter are the protector and provider of the home. The principle also tells that the man’s needs, values and requirements are valued higher than the women’s (Hirdman 2003).

Hirdman (2003) concludes that the gender order permeates everything, including our innermost thoughts, including the choices that we are not aware of and actions that are controlled by routines.

4.1.2 Class
Class as a concept intends to give knowledge about the dynamics that are created and exists between people in society. Previously, the focus has mainly been on financial resources when talking about class, but also other aspects such as influence and other forms of resources has become important to define what class means. Class is also something that people create, this is done to create a sense of belonging and identity. Depending on which class you belong to, you are different familiar and comfortable in different contexts. For example, maybe someone from the upper class is more familiar with opera than someone from the working class. The different classes are also a hierarchical order in which the upper class and the middle class are ideal (Mattson 2010).
For the sake of this paper, we will adopt sociologist Pierre Bourdieu way to define class based on the different forms of capital: economic, cultural, social and symbolic. He argues that economic capital aims at our financial funds and refers to actual assets in form of for example money. Cultural capital describes our tastes and preferences expressed by cultural belonging in areas such as music or theatre. There is a direct correlation between educational achievement and cultural capital. Social capital refers to a person’s social network, with a strong social network a person can use their contacts to get by or get ahead in life. Although the three examples listed above provide the basis for Bourdieu theory of class, he also discusses symbolic capital. Symbolic capital can be described as a context marker. In the way that certain assets only have a value in specific contexts and nothing in others. For example money might give you power in some contexts but among other people in other cases your education is the most relevant and valued (Bordieu 1999 referenced in Mattson 2010).

4.1.3 Ethnicity
Ethnicity is as Mattsson (2010) describes, a slightly vague term that can mean a variety of things. We have chosen the following explanation to formulate and interpret the concept of ethnicity. Ethnicity can be described as the processes that contribute to the human feelings of connectedness to other peoples and to a specific group of people. Connectedness may arise through a common denominator such as a place of birth, cultural, religious and linguistic similarities. It is created among people who share the same values and standards and have a belonging and identity by and within the group. A sense of belonging to a particular ethnicity impacts our identity and how we perceive ourselves. We often create a sense of ethnicity by comparing ourselves with others. We define ourselves in contrast to other conditions. This creates superiority and inferiority in society when certain qualities are valued higher than others. For example, various features that are considered to belong to a particular ethnic group be classified in a hierarchical order. In relation to intersectionality, ethnicity as a category seeks to explain the interaction between inequality and discrimination that arises and exists between categories and groups in the society (Mattsson 2010).

The constructionist understanding sees ethnicity as something that is changeable and situation-bound, meaning changes depending on the situation and the social context. Ethnicity is beliefs that the individual creates and reconstructs. How and with which ethnic identity as the individual defines himself with are not fixed but something that changes depending on the person and situation (Mattson 2010). We use this interpretation of ethnicity in our thesis to interpret our collected data.
5. Method and material

In this section we describe the chosen method and the execution of our study. A hermeneutic approach is used and the study is qualitative in the form of interviews.

5.1 Design

A qualitative and descriptive study was chosen for the study since it is consistent with the purpose of the thesis. The aim of a qualitative study is to implement deeper knowledge and understanding of the respondents' perception of their life-world. The qualitative study search deeper explanation and understanding rather than general conclusions that quantitative studies prefer. A qualitative study is not meant to generalize, as opposed to a quantitative study that examines a broader perspective with a greater amount of collected data. In qualitative study the research questions focuses on issues affecting the experience. In a descriptive study the researcher interviews people to seek as much detail as possible to describe their feelings and experiences in the situation they are in. The purpose is not to categorize but to get a detailed and nuanced picture of the individual’s life (Kvale & Brinkmann 2009).

5.2 Respondents

A qualitative study in the form of interviews was performed to collect data for this thesis. The purpose was to describe the social situation for elderly women who take care of a family member because of consequences of the HIV/AIDS epidemic. A strategic selection of respondents was made, which means choosing a smaller group of respondents to try to find variety and differences in the respondents’ answers. A strategic selection does not from the beginning have a certain number of respondents. Determination of when the data collection is complete is done along with the information obtained (Trost 2007). We chose a selection that consisted of a small number of participants to capture each person's experience and story to gain a deeper understanding of their lives. The goal was to find between four to eight people for interviews, we experienced that after five interviews we had gathered the necessary data for our study. The goal was to find respondents over the age 60, which was within the age demographic of the thesis. However, due to various time and resource constraints, the age of the caregivers was lowered slightly to include individuals between 57 and 70.

Our respondents are Maria 75 years, Johanna 73 years, Christine 73 years, Liina 57 and Magdalena 60. Four of the five respondents take care of children who lost their parents in HIV/AIDS. One of the women takes care of a man who is HIV-positive. The women have different ethnic backgrounds: Damara/Nama, Herero and Ovambo. We have not chosen to draw any conclusions based on their ethnic group and will therefore not present their ethnic background in this sense. We assume the description of the ethnicity we have described above (section 4.1.3, page 16), that describes another sense of connectedness between people.

In order to take account of our five respondents, we have chosen to use their own first names because the Namibian women interviewed were proud of their lives and felt it important to feel represented in the interview process. We have, therefore, in this case chosen to use their real first names out of respect and in consultation with our respondents.

5.3 Data collection method

The data was collected through semi-structured interviews that consisted of themed questions with the possibility of open responses. Kvale and Brinkmann (2009) describe semi-structured
interviews as conversations which are partially controlled, they consist of open-ended questions that are based on different themes with a specific purpose. This interview form is designed to seek understanding of the respondent’s perceived reality (Kvale & Brinkmann 2009).

The interview guide consisted of three themes: background, carer relationship and own experiences (compiled in Appendix 1). The background questions were chosen to be able to describe the respondents in a context of their surroundings and also to make them comfortable in the interview situation. The carer relationship theme focuses on the relationship between the care provider and the care taker which is an important aspect to be able to understand the family structure and the circumstances they exist in. The last theme concentrates on the care providers own experience, feelings and thoughts about the situation they are in. The aim with the questions is to capture the individuals’ true life story.

5.4 Procedure
The field study was conducted during a period of nine weeks, from the 16th of October to the 20th of December 2012 in Namibia (Africa).

We did not have an extended social network in Namibia, which affected our ability to find suitable respondents. Katutura, was chosen as a starting point for the study because some contacts were established in the area through the University of Karlstad.

Help to find respondents was received through a previously established contact within “Come to us”, a voluntary organisation for elderly in Windhoek. Along with our own research, the contact person helped us find suitable NGO’s and through these organizations we were able to find respondents. We came in contact with two NGOs working with HIV/AIDS: Catholic AIDS Action (CAA) and The Namibia Networks of AIDS Service Organisations (NANASO).

CAA was founded in 1998 and operates all over Namibia. They are a NGO working in different ways with HIV and AIDS issues. They focus primarily on people in need of help in the home, education, and counselling. CAA is as the name suggests a Christian Organisation but they help everyone, regardless of religious background (Catholic AIDS Action [CAA] 2012). NANASO is an organization that works to coordinate various AIDS organisations, raising awareness about HIV/AIDS at different levels of society. They are working to highlight and educate people about HIV/AIDS issues (The Namibia Networks of AIDS Service Organisations [NANASO] 2012). These organisations helped us by asking people that receive help in their home if they wanted to participate in the study. The respondents were informed that the research focuses on elderly people and how their lives are affected by HIV/AIDS. By this approach, we came in contact with five people who wanted to participate.

To create a safe environment for the respondents the respondents’ home was chosen to conduct the interviews. The home environment can be both reassuring but it can also complicate the interview situation. Seclusion was an obstacle during the interviews because the respondents lived with other members of their family and space became a significant constraint. This made it difficult to be alone during the whole interview session, and to be sure that the conversation was private.

Before the interviews began the respondents were informed of the purpose of the study. They were also informed about the Swedish Research Councils ethical guidelines. The time frame for the interviews was between one and two hours, but most of the interviews were completed
in about an hour. We adjusted the interviews depending on the respondents’ daily strengths and health.

The interview sessions were recorded by using a dictaphone. The interviews were listened through and transcribed in retrospect in order to properly reproduce the respondents’ answers.

During the interview sessions an interpreter was used since English is neither our, nor the respondents’ first language. We are aware that there might be a risk of misunderstandings, misinterpretation and information-loss when conversing via a translator. The interpreters’ role during the interview is to serve as a culturally and linguistically helping hand to the interviewer. If the interpreter is not professional, there is a risk that the person is taking over the interviewer’s role, or parsing occurs (Kvale & Brinkmann 2009). We did not hire a professional interpreter, but rather used an employee from the NGOs. They had a professional approach, which gave us the opportunity to lead the interviews.

We also strived to meet the respondents twice, the second time to check our compilation of interviews and gave them the opportunity to supplement their answers. The second interview was of a more informal nature where we conversed and checked if we understood the answers correctly in the first interview. This gave us the opportunity to reconnect with the respondent and gain a deeper understanding on how the elderly women experience their everyday life.

5.5 Data processing
Due to the nature of the date, we wanted to understand and interpret the research we gathered, we used a hermeneutical approach. A hermeneutic approach wishes to seek meaning in the texts interpreted. The hermeneutic circle is a central concept in hermeneutics and believes that knowledge is produced by understanding and comprehension. When interpreting a text the researcher looks at both the part and the whole and interprets accordingly in a continuous circular motion (Alvesson & Sköldberg 2008). After the interviews were transcribed, we tried to see the big picture in the text. The more data we gathered, we got new insights that allowed us to deduct different behavioural patterns. We went back continuously to ensure to totality of the data.

In the qualitative analysis various parts of the interview material is selected to illuminate the research. After having processed the text, we chose different themes that summarise the discovery during the data collection. Qualitative analysis studies an area and breaks it down to understand and categorize its various parts (Ryen 2004). In order to present our results we selected various quotes that reflected the purpose with the study and answered the question at issue. In qualitative studies, the procedure is not governed by any specific formula or rules, but can be free in its process. In the work of interviews general stages can be followed: first collect data, then analyse the data and finally interpret (Trost 2010). We apply the same approach by collecting data, selecting parts of the interviews, analyses them and finally interpret them.

5.6 Reliability, validity and dropping out
From a scientific approach it is always necessary to review the reliability and validity of a survey. Reliability measures the credibility of the investigation, that is, to judge the credibility of the measurable data. High reliability means that a survey produces the same results no matter who implements it, or at which point the survey has been conducted (Bell 2006). Some
factors that may affect the reliability of a qualitative interview are for example that the interviewer asks leading questions or that the respondents gives different answers on different occasions or when asked by different people (Kvale & Brinkmann 2009). In order to increase the reliability of our study we chose to return to our respondents for a second interview to check the compiled data from the first interview. During the interview sessions, we tried to be clear and repeat the respondents' answers back to them so that we understood the information correctly.

Validity determines whether you measure what you want to measure (Kvale & Brinkmann 2009). That is, if you ask the questions and perform the assessment in a way that is relevant to what you actually want to investigate, and if it answers the research question. The conclusions should be relevant to what is actually researched and based on the collected empirical data (Bell 2006). Before we conducted the interviews in Windhoek, Namibia, we prepared the empirical data collection by writing and testing out a set of questions for the interviews. We prepared an interview guide and conducted a test interview with our contact person in the field to ensure that the interviews meet the requirements for validity. We wanted to examine if the interview questions were properly placed and written, understandable for the respondents and good enough in general to obtain as a platform for our thesis. The reason for testing our questions was to make sure that the interview guide contained questions that were clear for the informants. By doing so we wanted to prevent the risk of misunderstanding and also make sure that the questions served its purpose. Even if we prepared and tested the questions before the field study we had to alter and adapt the questions to align them with the people we met.

Kvale and Brinkmann (2009) talks of the importance of being aware of the cultural differences that can occur when doing cross-cultural interviews. They emphasize the importance of being aware of the differences that might exist between the interviewer and the respondent, but points out that it is often difficult to detect. Factors that may be of greater significant, for example, cultural codes where the interviewer and the respondent does not interpret the same thing in a situation or that accepted notions or gestures have different meanings in different cultures (Kvale & Brinkmann 2009). During our interview sessions, there was a language barrier and differences in social unwritten rules. It could have affected the interview results since we could not communicate with each other without obstruction. During the process this was something we constantly reminded ourselves of but it still could have been distorted without our knowledge. We carried out our study in a different society and culture than we are accustomed to, which may affected our results.

5.7 Ethical considerations
It is important that the respondents are informed of their rights before the interview and therefore we were thorough in explaining and adhering to ethical guidelines. The Swedish Science Council presents four general ethical guidelines (Vetenskapsrådet [VR] 2012). The first is the requirement of information, which means that the informant is aware of the purpose of the study, the study is based on voluntary participation and that the informant at any time may choose to withdraw their participation in the study. The second requirement is informed consent from the prospective respondent. The third requirement states that any response that the informant gives is treated confidential. The fourth requirement is the requirement of use, which means that the collected data is only used for research purposes (VR 2012). The Swedish Science Council's model is adapted to Sweden and we used it as a basis for our interviews, but we also adapted them so that they would conform to the ethics guidelines in Namibia.
In addition to The Swedish Science Council ethical guidelines, we also took into account Kvale and Brinkmanns (2009) advice on ethical research. They describe that it is important to be aware that the interviewer is in the respondent's private arena, and that the statements made by the respondents should be treated confidential even when exploited and suppressed in writing. Kvale and Brinkmann (2009) also states that as an interviewer it is important to verify the gathered knowledge, and taking into account the confidentiality and the consequences that could occur for the respondent as well as the information they disclosed to the researcher (Kvale & Brinkmann 2009). We chose to use parts of the respondents' names because they requested it. However, we did not use their full name since it is difficult to fully predict the consequences for them if the information provided would be distributed. Further, the respondents’ whole situation was not described in detail so it would not be possible to trace them.

To perform an ethical study, we did extensive research on the country and its culture to not unconsciously ask questions that could be perceived as offensive. Since our topic can be of a sensitive nature we were careful and attentive during the interview sessions so that the respondents would feel comfortable in the interview situation. We did not ask questions that were beyond our subject to make the interview as professional as possible.
6. Results and analysis

Below the results of the empirical data collected during the field study in Windhoek, Namibia, is presented. The results are divided into themes that arose during the interview sessions. In this chapter alternating quotes are used to present and analyse the results and put them in a research position. The results answer the question at issue: How is the elderly generations’ daily life affected by the HIV/AIDS epidemic in the role of a care provider in Windhoek, Namibia?

6.1 Theme 1: A voluntary commitment?

"I feel that it is too hard for me, but I don’t have any options" - Maria.

Maria explains that the situation she is in is overwhelming. She does not feel she has any choice but to continue to help the orphaned children she now is taking care of.

"I am doing it out of my will, voluntarily, and out of my good heart. That’s why even though there is no food or there is nothing, we still manage" - Kristine.

The elderly woman above describes how she despite scarce resources is taking care of children who lost their parents in HIV/AIDS. She explains that she takes care of the children because she wants to. Some of the elderly women in the interviews care for grandchildren while others take care of orphan children or adults they have no kinship to. Some of the women describe that it was a voluntary commitment to become a care provider, while others say they had no choice and would have preferred that somebody else would have taken the responsibility. Those who express that they became care providers voluntarily at the same time say that there were no other options, and that the care taker would have been left alone without them.

"Okay this is the reality, they are rejecting him and so on so he needs attention, that is when I decided to: Okay I don’t have any resources to take care of you but I will take you in" - Magdalena.

Magdalena expresses how she came into contact with the adult man she now is caring for. The man was diagnosed with HIV and his family did not want to take care of him. The woman had no relationship to the man but when no one chose to take care of him she chose to do so, despite limited resources.

The elderly women describe that they have a sense of duty that makes them feel responsible for vulnerable people. They express in different ways that it comes natural to them to adjust their own lives to help others. This responsibility is not limited by biological ties, but extends beyond the nuclear family. This mentality can be understood by the women’s share of the same ethnicity. Mattsson (2010) explains how ethnicity can be understood as a sense of community between groups that share similar norms and values. From this perspective, the women have the same values and standards when it comes to care and who should provide it. They share cultural frame of reference, and this means that people within the same ethnicity feel an affinity to each other and also a responsibility to help each other. Although the families in our interviews do not know each other they all share the same core values that make them still feel an affinity to others around them. The concept of Ubuntu explains how people in African societies feel a responsibility towards each other (Sonal n.d.) This can help
to explain the strong sense of belonging and sense of responsibility the elderly women feel towards their fellow human beings even if they are not related or otherwise connected.

The Namibian family, the family sociology, consist of a wide social network and include the nuclear family, relatives and people who otherwise feel connection to each other (Foster 2004). We explain the cohesion and sense of duty the elderly women feel towards those they care for through the concept of ethnicity. However, we would like to emphasize that the sense of ethnic group solidarity expresses itself in different ways in different societies and between different groups. In the Namibian society this sense of responsibility towards one's own group is very strong. This is reflected in Namibia's, and other African countries', legal system where families can be held legally responsible if they do not take care of a family member who needs help (Foster 2004). The Namibian legal system also consists of Customary Law there are various traditional and customary responsibilities that revolve around old customs. The Namibian social welfare system is based on the notion that the family and the extended family takes care of each other and that they know and follow the rights and obligations towards each other (LAC 2005). The elderly women we interviewed can experience a voluntary commitment but it can also appear that this voluntary commitment has been created out of a requirement from society and the culture they live in.

6.2 Theme 2: The importance of education

"And in the beginning since I didn't understand HIV so well it was so scary for me that I would even wash a cup after they used it and so on. But after I got training it become so easier and now I am handling it really well" - Kristine.

The elderly woman in the above quotation explains how she lacked knowledge about HIV. She explains that after she received training it became easier to handle the disease since she understood how it was transmitted.

"Okay, no, I was alone because the time people did not have that understanding of HIV and AIDS and nobody wanted to take care of people living with HIV. And I was lucky now because this education so far, the training of HIV and AIDS, so I had this little bit of understanding how to take care. Because those years it is true, people if they heard that this person’s mom passed on by HIV, they would be far from you, because they might think that you might infect them. That is why, people were really far so I had to take care of them" - Liina.

Liina describes how no one else in the family wanted or dared to take care of the child whom she now cares for. She explains how others thought that if the mother passed away from HIV/AIDS the child would also be infected. The woman expresses that education about HIV/AIDS was a major reason why she chose to take care of orphans since she understood how the disease was passed. People distance themselves from the care taker in fear of getting infected. In agreement with Bourdieu (1999 referenced in Mattsson 2010) the cultural capital (in the form of for example educations) is an indicator of class. Education is not customary within these women's class and the lack of knowledge results in continuing beliefs in old prejudices regarding HIV/AIDS in the community. The elderly women expressed how the care taker’s closer family, which according to Foster (2004) traditionally would have taken care of their family member, chose not to do so out of fear of the disease.

None of the elderly women had an extended form of schooling, some missing it completely, but they had through NGOs received training on HIV/AIDS. Several of the women expressed
how their education and training made them aware and that they did not have the same kinds of prejudices about HIV/AIDS as people in their environment. We interpret this from that Bourdieu (1999 referenced in Mattson 2010) describes when he talks about class and how people have a cultural capital in the form of for example education. Our respondents come from a class where education is not common or valued and therefore knowledge about HIV/AIDS is inadequate. The women do not possess high cultural capital since they have a limited education and do not work skilled occupations. The elderly women who had acquired a cultural capital in the form of education were more likely to take care of the orphans or HIV infected since they had knowledge about HIV/AIDS and how it is transmitted.

The women raising children said that education was an important aspect. Regardless of the lack of money for fees and other necessities for school, education was a priority. This may indicate an awareness of the importance of cultural capital in the form of education. That cultural capital can be important for getting ahead in life. The goal for the elderly women was that the children would get better conditions than them and education was considered a contributing factor for that.

6.3 Theme 3: Gender influences

"My husband travels a lot and he doesn’t restrain in Windhoek, but whenever he is there he can be able to help, but he doesn’t really help all that much and the other thing is men in Namibia. They like alcohol; they spend their money on alcohol. So instead of spending it on kids they will only have time for alcohol. We cannot really get help from our husbands“ - Liina.

This quote shows how the woman experience herself to be alone in the role as care provider for the children even if she is not the sole wage earner in the household. The elderly women feel that the men choose alcohol before her and the children, which she considers to be common among men in Namibia.

The interviewed women all showed a general distrust to men. Whether the elderly women were in a relationship or had contact with a man in any way or not, they did not have any faith in men. It was not expected that men would help the woman in her role as a care provider or that the man would treat the child or the woman in a good way. One woman for example describes how she chooses not to meet men because she does not believe that a man would treat her children well. The men are thus "not worth the risk". According to Hirdman (2003) the male dominance and female subordination permeates almost everything, from our thinking to our culture. The man possesses the most power in the family hierarchy and male negligence and absenteeism in regards to raising children is the norm. The women's choice not to get a man can be explained by the potential change in the relationship and what that could mean for her household. All the women we interviewed were breadwinners of their family even if one of them had an absent husband. The women have a lonely position as care providers, but they are also self-determined and control the household. Hirdman (2003) describes how the man in a normative manner is the head of the household. One reason that women choose not to have men in their lives could be because they are afraid of losing power over the household, since men usually have more control over it. Our study shows that the women would rather stay alone, than be subordinate.

Consistently during our interviews we noted that it was only women who stood as care providers, even if there were men in the household. A fact that was also described as a
problem of the women we spoke with. Campbell and MacMillan (2012) describes that most care providers are women and they are more likely to adapt their lives in order to care for others. Hirdman (2003) talks about how women are expected to know their place and what chores is expected of them, the women should look after the home and children while the man should be the breadwinner. The woman is born into a caring role, where she is destined to give birth and raise children. In line with this, our respondents, are also brought up to be care providers and care is something that is expected from them and is seen as a natural part of their lives according to their culture.

Hirdman (2003) talks about the gender order and that women and men, already from the beginning, are assigned chores that are included in the female and the male role. The author expresses that today’s society still is governed by this gender order where male dominance is the norm. Based on this pattern, it is for example, the woman who will stay in the home and care for the children. Our respondents follow this gender order, when they, through their answers makes a clear separation between what is considered female and male chores. The woman in the quote above describes how the man has the ability to help out in the household and with the children, but that he would prefer to drink, instead of being at home with her and the children. Even if the man has no employment, he does not feel any responsibility to help in the home, which originates from the prevailing gender order in which the man belongs outside the home doing different chores. The man's needs to take precedence over the woman’s needs, which is consistent with what Hirdman (2003) has argued to explain society’s gender order, where women are subordinated.

Some of the elderly women had been care providers for their entire lives. They were unable to get an education or full-time job, because they have obligations to the home and family. Others became care providers at an older age, where they described the change in roles as a great difference in their daily life. Hirdman (2003) argues that the gender order creates a system that consists of a number of cooperating processes that further creates patterns that permeates everything in our society. These patterns can be linked to the Namibian society, where the woman is the one who according to the norm is intended to be the care provider. The women we interviewed expressed a feeling of acceptance and there were never a question whether they should continue to provide for the care taker, their concerns were focused more on maintaining this role as material conditions were making it difficult to continue. Hirdman’s (2003) gender order adequately describes this situation as a strong caring role is assimilated into women. They feel a personal responsibility because of the role they have been ascribed as women.

6.4 Theme 4: Poverty and social exclusion

"It is not easy to raise a child, or even look after somebody while you are a pensioner. And everything is just like, I am just earning 500 and everything comes falls down on my shoulders" - Johanna.

Johanna describes the difficulties she has when taking care of a family member at an older age. She also expresses that the tight economic situation is a big problem. When the elderly women were asked about their daily lives they all repeatedly describe that they live in an economically vulnerable situation. That the women have difficulties affording food, school fees, clothing and other primary things is a recurring topic.
"It’s the money. Because with money you have to do everything. You have to take care of the child. You have to buy him, feed him, everything is just money. And if you are just one person who is earning only a 500 from the pension /.../" - Johanna.

The elderly woman explains how economic resources are essential for her and her family to survive the day. She expresses that her income is too exiguous for the household to cope financially. That the elderly women have a huge concern about not having enough financial resources to meet their daily needs is something that was constantly expressed during the interview situations. All the women expressed that a state sponsored pension was their main source of income, except the younger woman who was still working, and that the wages and pension were insufficient to meet expectant household expenses. One of the elderly women said that she has applied for child maintenance grant, but has yet to receive a response from the authorities after two years. The other women did not express that they had any knowledge about the grants provided by the government.

The elderly women explain how resources are barely enough for themselves. Their precarious financial situation is further exacerbated when they need to take care of more people than themselves because of the HIV/AIDS epidemic. We interpret this from what Bourdieu (1999 referenced in Mattson 2010) describes with the concept of class. The elderly women have a lack of economic capital from the beginning because of their class affiliation. The situation is exacerbated by the role of being a care provider role because it requires more financial resources to care for others. As breadwinners of the family, they share their income with the children or the person living with HIV/AIDS. The elderly women we interviewed do not come from a wealthy family, they belong to a class where liquid assets are unavailable. The women we interviewed belong to a class where financial capital is inadequate and where the ability to hire paid help therefore is limited. In Namibia, the social safety net mainly consists of the family (Foster 2004). It would therefore neither be accepted in their culture that someone other than family performs the help.

Brown (2011) has also observed that elderly end up in a more economically vulnerable situation as care providers and her study concludes that the elderly have a remarkable adaptability to changed circumstances. We can compare this with our results, that showed how the elderly constantly adapted to new requirements in finding income and pay for expenses or take care of additional family members.

"Then taking care of the others I also need to be taken care. But I don’t have anyone to take care of me, in the way I wanted to be take care. Maybe to be assisted with these stationaries or to be assisted with water or electricity bill. It’s a troubling experience for everyday life" - Johanna.

Johanna expresses in the quotation that she needs care herself, but have nobody who could provide it. The elderly women describe how they are not only in need of money, but also need other forms of emotional and physical support and assistance. All of the elderly women lack an extensive social network. Social capital can make it easier to get ahead in life (Bourdieu 1999 referenced in Mattson 2010). The women explained how people distance themselves from them when they become care providers, alternatively that the women always have had a lack of help from a social network. All the elderly women expressed that they felt alone and vulnerable in their role as care providers, since they do not have people in their lives that can provide assistance. de Klerk (2011) also talks about how the elderly as a result of the role as a care provider loses its own security at old age in the form of economic stability. We observed
that the elderly were in a both socially and economically more vulnerable situation as a care
provider.

Thomas (2006) expresses that care providers experience isolation, exclusion and
stigmatisation because the person they take care of is living with HIV/AIDS. We have in our
study observed a similar situation for our respondents. The woman who took care of a man
living with HIV was met by prejudice from the environment and also various forms of
discrimination. The women who took care of children who were orphans because their parents
passed away in HIV/AIDS also faced similar forms of stigma and discrimination. In their role
as care providers, they lose a potential social capital in the form of help from other people.

6.5 Theme 5: Demands on the elderly

"I am very old, and even if I am very old I'm going to stay with them until I pass away"
- Kristine.

Although Krisitine feels old and frail she still express that she will continue to be a care
provider and take care of the children until she pass away. The elderly women do not reflect
much about tomorrow, but take each day as it comes. The women express an awareness of
their age, and the fact that they are getting older and will not live forever. Although they lack
the resources and physical ability they will still care for those who need it.

"No matter how difficult the situation is, I still have to be happy and keep going to a
point. So I will continue doing good in times that I can, like for the time that I am alive"
- Magdalena.

The woman above choose not to think about the negative things that can happen in the future,
and instead focuses on the value of the person she is taking care of. She is trying to create a
positive atmosphere for the person receiving her assistance.

As Foster (2004) and Brown (2011) expresses, the traditional safety net in the form of
extended family is bursting as the younger generation moves to cities and prioritise work or
their interests instead of caring for the family. The elderly get increasing responsibility in
taking care of sick or orphaned children who lost their parents to HIV/AIDS (de Klerk 2011).
We have in our study observed this situation since the elderly expressed that they were the
only option as care providers. It seems that the elderly are those who mainly feel a sense of
responsibility to care for those who need it and are left alone in their role as care providers. As
de Klerk (2011) describes the elderly are the last generation that grew up before the
HIV/AIDS epidemic was a pronounced social problem in African countries.

The elderly’s upbringing is to a great extent was characterized by ubuntu, the feeling of
connection with people regardless of differences between them (Sonal n.d). They have been
imprinted by a mentality where they have a natural responsibility towards their fellow human
beings. The older generation experienced a transition in the middle of their lives when
HIV/AIDS was discovered and rapidly spread. The younger generation grew up during a time
when HIV/AIDS was a widespread social problem and our reflections are that the younger
generation because of HIV/AIDS are forced to mainly take care of their own needs and not
have the ability to provide for other than themselves and their nuclear family. This may be a
reason why the younger do not feel the same strong sense of responsibility as the elderly do
for the extended family and others. From this we draw the conclusion that the elderly become
primarily care providers, since the younger generation is not as influenced by the philosophy of Ubuntu, and thus do not feel the same strong sense of responsibility for their fellow human beings. It seems the younger generation do not revolve their lives around the family in the same way as the elderly.

de Klerk (2011) express how the older generations of African societies today have to adapt to many new circumstances compared to what they previously did or are accustomed to. We came to a similar conclusion, since some of the women we met had to take on a caring role at an older age, which was a new and unexpected situation for them. Because of HIV/AIDS they had to provide and give help to others instead of receiving it themselves. Bergström\(^2\) speaks of second parenthood in relation to when elderly are forced to become parents again at an older age. We have seen this effect in some of the older women we interviewed became care providers for children and therefore had to adopt a parental role again. We have observed that even if some of the women expressed that it was a voluntary commitment, the relationship occurred under conditions that seemed forced since no other care taker was available. We interpret that second parenthood exist because elderly to a greater extent is characterized of African traditional culture where the family will be taken care of by its own members, which includes extended family.

6.6 Theme 6: Fear of the present and the future

"Sometimes I am sleeping then I can't sleep because I am thinking, I am thinking about tomorrow. Where can I go to get something to eat" - Maria.

This elderly woman expresses her worry about the future, how they will manage their primary needs in the near future. All the elderly women express some kind of fear of the future but mostly in the short term. Something all of the respondents shared in common was the absence of a plan for the long term. They are forced to live in the moment, day by day, and what needs have to be satisfied in the short term.

All the elderly women described an immense love and warmth to the ones they take care of, but also the feeling of being inadequate. They express a sense of guilt because they do not have the ability to support their care taker in such a way they would have wanted. They feel inadequate in their situation since they do not have enough resources. According to the women the most important for the care taker is financial security and love. This can also be explained with an expression of solidarity within the ethnicity and how the women feel a deep responsibility to care for someone in a sufficient manner. Also gender is an influence since the elderly women say that they consider it as their role and not the men's. According to Mattsson (2011) can women's primary responsibility as care providers be understood as something that is remained written, something the women possess and identify with from birth. Until now the women has been dominating the role of caring which appear to be the norm within care.

"My daily life is a bit tough, not a bit tough, it’s tough. Because I am not happy, caring for these ones and other things and all the problems I mentions for you. /.../ So

\(^2\) Lars Bergström, lecturer, Karlstad University, 2012-03-12
everything, my daily experiences are not the same and every time. Sometimes it’s getting a bit better. But the most of them are, I am worrying and stressed out. And I am so wondering what the kids will eat the next time. After they have eaten the porridge, the little porridge that they have in the morning. And then I am worried about them. So my daily routine I myself is not happy. I can’t even focus and I am more like, taking care of myself. I am rather taking care of the others” – Johanna.

The woman talks about how she feels about her daily life and the effort that the everyday chores involve. She describes that she never feel glad or happy and that she always carries an inner worry and anxiety about how they will manage tomorrow.

There existed no "I" when the elderly women talked about their daily lives. They only spoke of what was best for the family or the care taker. It is difficult to distinguish the individual during the conversations, they exist as a unity with focus on what is best for the family. We explain this by ethnicity as Mattsson (2010) declare when she refers to the solidarity and connectedness among people. It seems that this sense of duty is very strong among the women we interviewed and that there is a clear community and family perspective that makes the individual alone unimportant.

“Most of the time it is just normal the way I live but what affects me more is the fact that I can’t take care of them sometimes. And we don’t have anything to eat sometimes. The fact that I cannot take care of their [the children] school fees” – Kristine.

Kristine explains that she is worried about how she will take care of the kids, and how she will be able to pay the costs that this care entails. None of the elderly women expressed worry about their own life, but was mainly concerned about what would happen to them they care for if they could not provide. All the women described in some way how they put the care taker’s needs above their own. When we asked them questions about what they personally wanted or desired in their everyday life, they all said something that the care taker needed instead.

“It is like to me there is no difference; I cannot say there is a day when I feel happy. /.../ Everyday is like a struggle” - Maris.

The woman describes how her living situation manifests and describes that every day feels as a struggle without joy.

Similar to what Thomas (2006) discovered in her study, the women in our study expressed that the heaviest was not the physical burden of caring for someone else, but the mental and emotional stress which mostly affected their well-being. The women we interviewed described that they felt hopelessness in their situation and that they had little or non-existent social and emotional support. They said that they did not reflect about how their lives are affected by being a care provider or that they simply accept that their lives are not easy and that they rarely feel well. de Klerk (2011) argues that a recurring topic during her studies was how the elderly were aware of their physical aging body and how they were dependent on their physical strength to cope with their daily life. The women we interviewed uttered a kind of awareness of the body and the physical strength diminishing, but mainly in relation to what their reduced strengths could mean for the family. Mainly the elderly women were concerned about what would happen to the care taker if they were to pass away. de Klerk (2011) also found in her study that the elderly expressed a concern about the future in relation to their
physical abilities. Women's concerns about their physical ability to provide for the care taker was not directly expressed during our interview sessions but it was implied through the way they described their thoughts and concern about the future.

"Definitely there were times when I just felt like giving up /.../ But I just pulled through you know, tried to motivate myself. Let me just do it for today, and then tomorrow morning I would again go like, let me just do it for today” - Magdalena.

The woman in the quote explains how she handles her everyday life as a care provider for a HIV-infected man. She describes that some days are very hard, but that she tries to take one day at a time order to cope with the situation.

de Klerk (2011) describes how the relationship between the care provider and care taker can change over time and that the environment affects this relationship. In our study we observed that in the beginning of the relationship the care taker was the one who were dependent of the care provider, but over time a dependency was created for the care giver as well. Providing care became an important part of their lives, interdependence arose where the care provider also became dependent and allowed a large part of their lives to revolve around the care taker. In our interviews it was expressed that the care taker included a lot of effort but also became the source of joy and self-fulfilment in the elderly women's lives. We believe that those who became care providers at an older age rather than earlier in life may have had a social network and different focus in their lives. But because of the socially isolated situation of becoming a care provider the care taker became an increasing part of their lives. Finally, the situation became one of both joy and sorrow. de Klerk (2011) describes care as a process that changes the relationship over time and that care becomes an identity formation that can lead to role changes. de Klerk (2011) further describes care as something that is exercised not independent of the environment. The relationships between the care giver and the care taker are also affected by other people's perceptions. The same way the socially isolated role of the elderly women we met had resulted in a change in the relationship between her and care taker.

6.7 Summary
To summarise our results we can conclude that the elderly women in our study feel a strong obligation and responsibility to become care providers regardless of biological ties to the person they care for. They do not see to their own needs but prioritize them they take care of. There is no "I" feeling, but rather a sense of family perspective where the focus is on what is best for the group. This requirement appears to be strong for the women and it is never a question whether they should take care of the care taker but just how to do it. Even though they express that they are living in a difficult situation and do not feel good in their everyday life. Although the women share all the resources they have they still feel insufficient in their situation because they cannot provide the care that they want. A reoccurring theme is specifically the lack of financial resources. There is no despair in what the women personally lack or miss out on, the focus is only on what they can or want to give to the person they care for.

We have found that among these elderly women there is a lack of economic, social and cultural capital. We have noticed that the women we interviewed feel alone in their situation, and that their everyday life includes concerns about money. The consistently meagre income makes financial resources something current and to find resources for the day is something that is an ongoing concern. Money is an important topic when they describe the need for them to cope with their daily situation in terms of food, electricity, water and other necessities such
as school fees and school uniforms for those who take care of children. The elderly women still choose to take in and care for people who need it, even if it means additional stress for them in their everyday life in the form of scarce economic resources and social exclusion because of the stigma that exists with HIV/AIDS. We also observed that women who possess cultural capital in the form of training and education about HIV/AIDS seem more likely to care for children or those living with HIV/AIDS. The women who take care of orphans emphasize how important education is for the children so that they will have better prospects for the future. Therefore they prioritise expensive school fees despite the household's scarce financial resources.

The elderly women express a distrust of men and have no confidence in them in general or in regards to help in the home or in the role as a care provider. The women consider care providing as something that they must perform as part of their duties.
7. Discussion

In this section, the thesis is concluded and a discussion of whether the purpose and question at issue has been answered is presented. Future research within the field will also be suggested.

7.1 Conclusion

The purpose with this thesis was to describe the social situation for elderly women who take care of a family member because of consequences of the HIV/AIDS epidemic in Windhoek, Namibia. The question at issue was: How is the elderly generations’ daily life affected by the HIV/AIDS epidemic in the role of a care provider in Windhoek, Namibia?

The older generation in Namibia has in previous research and studies had an inconspicuous role, a fact that was discovered when searching knowledge in the field. The situation of the elderly has in recent years become a topic of interest and the growing thirst for knowledge is reflected in the media and public debate worldwide. The thesis want to help create further interest and increase knowledge in the social area that focuses on elderly and their lives, starting from Namibia. We believe there is a missing piece in the knowledge about the older generation’s lives and want to be a part of completing it. The hope with this study is that it will help to provide a basis for further studies in the field, so that the situation of the elderly is highlighted and explored.

In conclusion, the results of the thesis show the following: The elderly women who take care of someone because of HIV/AIDS live in a socially and economically vulnerable situation that negatively affects their psychological well-being. They do not have capital in the form of assets and economic resources, they have little education and lack social contacts. The care provider role seems to complicate the situation of elderly women in all areas of their daily lives. The economic and social vulnerability is strengthened by being a care provider and discrimination and stigmatisation arise when taking care of someone because of HIV/AIDS. People in their surroundings distance themselves from these women because they take care of someone who has a connection to HIV/AIDS. Another conclusion is that women's daily life revolves around a search for money this is done to afford food and other necessities to survive and to provide for the care taker. They express that they do not feel well but feel inadequate in their situation however they do not consider any other option, because no other solution seems possible. A result is that women's lives largely revolve around the care taker and give little focus left to their own needs and what they want to achieve in life.

The result is presented in different themes but in reality they interact with each other. In the same way the various theoretic concepts interplay and cannot be understood isolated. Through analyse it was discovered that it was difficult to understand the situation of the women without also involving the family structure and its impact.
7.2 Method discussion

Our results have importance because it reflects an essential part of how elderly women’s social situation manifests itself in the shadow of the HIV/AIDS epidemic. Elements justifying the credibility of our research are that we have used a proven data collection method in the form of semi-structured interviews. It gave the respondents the opportunity to give open-ended responses with space to express themselves freely. To ensure that we understood the answers correctly, we also visited the respondents a second time to verify the answers we received and made changes if necessary.

We have been well prepared and were erudite about the country and existing culture to avoid misunderstandings. The interviews have been recorded to be able to reproduce the respondents' stories in a correct way without the possibility of subjective interpretation. The ethical principles of both the Swedish Scientific Council and the culture we met in Namibia have been followed. We have been in contact with our respondents from NGO’s where they on a voluntary basis registered to participate in our study. This argues that the respondents participated out of a genuine desire to share their life story without any form of coercion or external forcing. The study has also been carried out in a systematic order and we have presented the approach in such a way that others can perform similar studies.

The used method in the study was qualitative, which means that the research aimed to achieve a deeper understanding of the people we met. The study was not intended to be general assessment of the situation in any type of universal sense, since it is done in a smaller scale with a different purpose. However, we believe that the conclusions we have drawn from our results also can be connected to the societal level since the same power structure prevails there. Among our respondents, we have met people who share a different culture than our own. This could mean that there aresilent codes in both the language and the culture that we have not observed. We are aware that we may have missed implicit aspects because we do not share the same culture. There is also a risk that the respondents did not want to share all information with us since we are outsiders, in the same way, this also be a chance for them to share with someone outside the culture who will not judge them according to realized cultural norms.

We did not have an extensive social network in Namibia, which lead to difficulties in finding interview subjects on our own. We used the help from NGOs to find suitable respondents, which may have given results different from the general population since the women we met through organisations had gained some knowledge and education about HIV/AIDS. The people we were introduced to are also chosen by the NGOs, which may have influenced the selection.

There is a risk that the results have been distorted for various reasons. We have chosen to analyse from an intersectional perspective, which means that we can see how different power structures affect superiority and inferiority in society. We chose to limit ourselves by using the concepts of gender, class and ethnicity in our analysis. There are other power structures we could have taken into consideration such as sexuality. Perhaps another dimension would have been presented if we also used it as analytical tool. For example we never asked about women's sexuality, although, during the interviews some of the women expressed through their story that they were heterosexual. However, we cannot assume that all women have that sexual orientation and we do not know what impact their sexuality had in their lives.
We also got to experience a few negative aspects when coming from a different culture than our respondents. There is an assumption that one is wealthy when originating from a western society and therefore some people asked us for money during the interview sessions. We cautiously want to point out that there could have been a risk that the women wanted financial support in exchange for telling us their story which may have influenced their responses.

The language is also an aspect that is important to take into consideration. We could not communicate freely during the interview sessions since we spoke our second language, English. The interpreter was not a professionally trained interpreter and neither had English as their first language. The respondent could express themselves in their native language but the translation to us could have been modified depending on the interpreter’s translation. Likewise we cannot be confident that our questions were expressed in such a way that we intended. We have had to rely on the interpreter’s translation and therefore must take into consideration that the respondents’ answers not have been literally rendered to us. We may also have misunderstood the interpreter and the interpreter may have misunderstood us or the respondent. Overall, there is a risk of information-loss because of the language barrier.

Our study has been obstructed because of problems finding current research and relevant literature within our chosen field of research. There is no documented research on elderly women in Namibia who are care providers which means that we had to research studies in related areas which cannot be fully related to our study. The statistical data in the country is also inadequate, which made it difficult to obtain reliable statistics on the information we collected.

7.3 Result discussion
Our results have shown that the elderly women we interviewed experienced a complex everyday situation consisting of social vulnerability. Something that is consistent with what previous studies have shown in similar areas. But where can elderly women find help to handle their everyday situation?

Namibia has a kind of social safety net in the form of maintenance (LAC 2005). The pension is used by most of the women we interviewed but other forms of maintenance are rarely applied for. It does not involve any extensive financial support but we believe that an additional source of income could facilitate the elderly women’s situation considerably. Still the support does not seem to be utilized, only one of our respondents expressed that she had applied for other grants. What is the reason the women does not apply? Do they have the opportunity to receive it? We believe that the information about the help they can receive in the form of grants is inadequate, the women do not know their rights or where to turn. We believe that a threat of lot of paper and a long bureaucratic process can be something that intimidates women that already are in a psychologically stressful situation. How are social support designed to enable people to apply for and actually get the support they are entitled to? Are there ways in which the state can facilitate grant dividend? We suggest, for example, that more information is provided, facilitating the application process, alternatively a kind of automatic contribution for those who take care of children. It would have been interesting to get specific and accurate figures on how many people use this kind of support from the government, because these numbers we have not been able to find.

Where is the help for those who are taking care of someone in their family because of HIV/AIDS? Almost one-fifth of the population is living with HIV/AIDS. Maybe it is time that the country take further measures to prevent disease and protect those affected by the
consequences of the epidemic. Who ensures their rights? We want a law that deals with those living with HIV/AIDS in particular, that a special form of support or grant is designed for them. If regulations protected the people living with HIV/AIDS and those affected by the disease maybe stigma and discrimination against them could be prevented in the future.

Since it is primarily women who take the role of care providers (Campbell & MacMillan 2012), we believe that care providing creates larger gaps between men and women in society. Since women keeps being the ones that take on the caring role it contributes to gender stereotypical division between men and women. Women who at an early age begin to care for someone else suffer a higher risk of dropping out of school and the labour market (Campbell & MacMillan 2012). This leads to reduced opportunities for women to support and educate themselves. This causes consequences on a societal level where women have worse opportunities than men to raise their standard of living. When women become care providers at an older age they encounter difficulties to cope financially because of the economical strain in supporting more people. It is not only women’s economic capital that is affected but also the social capital is significantly impacted.

de Klerk (2011) express that the elderly lose their own old age security when they at an older age need to give care instead of being able to receive care. The results in this study show that the elderly get an aggravated situation through the care provider role. That the elderly forced or voluntarily adopt a care provider role raises questions what it in the future might mean to grow old in Namibia. Since the Namibian society does not offer an extensive public safety net, it relies on the family as the primary care provider. This social safety net is starting to fail since the younger generation prioritise job and education instead of taking care of family members in need of care (Foster 2004). So what happens when the first source, the family, disappear and no longer have the ability to act as the first care provider? When there is no family, or when they do not take on the responsibility as care providers, the NGOs in Namibia that catches those who have fallen through the ordinary social safety net. Today Namibia is classified as a middle-income country and the global grants will therefore be reduced because other countries get prioritised, leaving the so much needed NGO’s on increasingly scarce resources (Bautista 2012). So which option remains then? The governmental social safety net in Namibia and other African countries are not adapted to take care of people in vulnerable positions to the extent that may be required. If the traditional safety net in the form of family and extended family continues to be settled, other options in the future will be needed.

Maybe another form of social safety net needs to be built up? To obtain these options further research is required in this area.

7.4 Further research
We wish that more research is done in the field so that a picture of how reality and everyday life actually appear for the elderly care providers in Namibia. In order to fight poverty and spread knowledge of HIV/AIDS negative consequences, we need to view the current situation in order to put resources in the right place. In order to find alternative methods to change the current situation research and documentation is needed. We believe that this ultimately will benefit the country and the people for a brighter future. The elderly we have met is doing a tremendous job but they will not be able to stand alone as care providers in the future, which is the direction that the development currently seem to be heading. Therefore, it is essential to identify what the situation looks like for these people and if this system is sustainable in the long run. And if not, how can we best help families and, is it even possible that the families in
the future will have the opportunity to stand as care providers?

In line with further research we also believe that education is needed in order for discrimination against families who have connection to HIV/AIDS can be reduced. We have through our study seen the importance of educating people about HIV/AIDS and the need of continuing research and the consequences that currently exists for care takers and care providers. There is a possibility that people can relate to HIV/AIDS in a different way if they have knowledge about the disease. Just as the women in our interviews were more likely to become care providers when they understood how HIV/AIDS were transmitted. Because of lack of education about HIV/AIDS the disease continues to spread and therefore more people are put in a position where they need help. A growing number of care providers are needed and more elderly are placed in a vulnerable position, as they are often those who take care of orphans or HIV-infected.

The older generation does a great contribution for the people in the AIDS epidemics shadow. Yet no extensive research has yet been conducted to identify their situation or what the future has to offer. Can social work better adapt to capture vulnerable groups that exist because of HIV/AIDS? How will care providing appear in the future? Where can elderly turn for help? In conclusion: What about the elderly?
8. References


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9. Appendix 1 Interview guide

BACKGROUND

- What is your name and how old are you?
- What is your marital status?
- How is your living situation? (For example: house or apartment, size, location.)
- How do you make your living? (For example: pension, salary, help from family or someone else).
- What form of education do you have?
- Do you work or what profession did you have before you retired?
- Who lives in your household?
- Who is the breadwinner of the family?

CARER RELATIONSHIP

- Who do you care for? (What relationship do you have to this person?)
- In what way do you care for this person? (For example financial or physical help) Example?
- How did you become a care provider for this person? (For example was it voluntarily or enforced?)
- Were there any other options than you? (For example health care or other family members)
- Do you receive any help caring for this person? (For example from other family members or someone else?)

OWN EXPERIENCE

- How is your daily life affected by taking being a care provider? (For example socially, financially.)
- In addition to taking care of someone else, do you yourself need help to handle your everyday situation? How?
- What do you consider the most essential for you in the role as a care provider?
- What do you think is the most important for the care taker?
- How do you experience your daily life?
- Do you have anything that you would like to add in order for us to understand your situation better?