

UNIVERSITY OF BOTSWANA

FACULTY OF HEALTH SCIENCES



SCHOOL OF NURSING

**CHALLENGES FACED BY FAMILY CAREGIVERS IN THE HOME SETTINGS IN
LOBATSE**

BY

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**A Research Essay Submitted in Partial Fulfilment of the Requirements for the Master
of Nursing Science Degree**

SEPTEMBER 2016

DECLARATION

I, Keiponye Sebogodi, do hereby declare that the work contained in this research essay is my original work and has never been submitted to any university or for any award. All sources utilized in this research essay paper have been acknowledged accordingly.

Student's Signature:

Date:

Supervisor's signature:

Date:

DEDICATION

I dedicate this research essay to my family for their unwavering support especially my husband, Mr Lesoto Sebogodi and sons Ernest B. Sebogodi and Raymond L. Sebogodi. I thank them especially for their patience when I had to take time off my duties so as to carry out research to complete this study.

ACKNOWLEDGEMENTS

I would like to start by thanking my supervisor Professor N. Phaladze for guiding me throughout this research essay. She was very supportive, patient and encouraging.

I would also like to thank my husband, Mr Lesoto Sebogodi, my sons, Ernest B. Sebogodi and Raymond L. Sebogodi for being patient with me when I was studying.

My thanks also go to my employer, the Ministry of Health and my colleagues who allowed me to carry out my studies even when I had to miss some of my work commitments.

Lastly, I would like to give thanks to the almighty God for giving me the strength to carry out this work even at a time when I seemed to lose hope.

ABSTRACT

Background: Resource constraints in the public health sector led to the adoption of community home based care to complement the formal health care. Currently, there are 3642 people registered with community home based care in Botswana. Challenges facing caregivers are numerous and include shortage of finances, lack of transport to facilities, and low education level.

Objective: To investigate the challenges faced by family caregivers when providing care to clients in the home settings in Lobatse.

Methodology: Deci and Ryan's Self Determination Theory will be used as a framework to guide the study. The study utilizes an exploratory and descriptive design. Purposive sampling will be used to recruit participants. Thematic content analysis will be employed to analyse data.

Conclusion: The study has implications for programming and policy, and training for family caregivers and recommendations for quality care will be made.

Key words: community home based care, family caregivers, challenges, Botswana

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Chapter 1.0: Background of the Study

1.1 Introduction

In Botswana, it is common practice to care for loved ones in the comfort of their homes. This usually occurs when someone is sick, disabled or aged when they need help with activities of daily living or when they have been discharged and still need care. According to a study by Pindani, Maluwa, Nkondo, Nyasulu and Chilemba (2013) in Malawi, most patients with chronic illnesses go home when discharged while on-going care is still required. Care will then be continued at home by close family members like sisters, aunts, parents or even children. Another study by Kangethe (2011) indicated that most family caregivers are women, the girl child and elderly women who are uneducated and have no source of income. In a study in Taiwan, Wu (2009) reported that the educational level of family caregivers is low and that females account for 60-85% of family caregivers. This is an indication that family members especially females play a very important role in the implementation of community home based care programme.

Community home based care (CHBC) has been of great help to the overburdened health services in Botswana. The programme was established due to the HIV and AIDS scourge as more people became sick and the health care delivery system could not cope with the large numbers of sick patients. According to the Ministry of Health (2010), resource constraints in the public health sector led to the adoption of community home based care to complement the formal health care system in the care and support of chronically ill patients including people living with HIV and AIDS. Mmopelwa, Ngwenya, Sinha and Sanders (2012) stated that the home based care programme in Botswana was initiated partly to augment hospital or clinical care by reducing the health care costs associated with chronic illnesses such as HIV and AIDS.

According to the Ministry of Health (2012), the programme approach and strategies were a result of feasibility studies done in 1995 and 1996. Since its establishment in 1995, community home based care has been integrated into the existing primary health care structures and health protocols. Despite its integration into the health care system, the programme has been riddled with so many challenges that threaten the quality of services it is meant to provide.

Currently, there are 3642 people registered with community home based care in Botswana. According to K. Malesela (personal communication, September 10, 2015), a home based care officer at the Ministry of Health, Botswana government spends 11 million pula yearly on the upkeep of people registered with home based care programme. This money is used to purchase necessities such as disinfectants, diapers, linen savers, gloves and to pay allowances for CHBC volunteers. The officer stated that there is also an extra 46 million pula allocated for the food basket, mattresses and other equipment for these clients. She further said that the money allocated is usually not enough and they end up asking for more money.

This study seeks to investigate the challenges faced by family caregivers in community home based care in Lobatse and how those challenges could be addressed to improve services to those in need. The findings of this study will help the government and donor agencies like U.S President's Emergency Plan for AIDS Relief (PEPFAR) to determine more effective support strategies for home based care clients.

1.2 Statement of the Problem

In Botswana, challenges facing caregivers are numerous and include shortage of finances, gender imbalance in caring, lack of transport to facilities, low education level of family caregivers and others. The majority of these family caregivers are mostly women especially the elderly and the girl child who are uneducated and unemployed with no source of income

to care for themselves (Kangethe, 2011 and Wu, 2009). This is a problem in itself because if one cannot support oneself economically, she or he cannot afford to support another person in need.

According to a study carried out in Australia by Remedios, Thomas and Hudson (2011), in some families there may be loss of two incomes; that of the patient and the caregiver which renders the caregiver financially disabled. Someone in need can only be able to adequately support a sick relative if there is adequate support from somewhere else. According to Mmopelwa et al (2012) the majority of primary caregivers are from households without cash income. The authors argued that, without cash income, caregivers may not adequately provide even the most basic need such as food for the patient. They further observed that this can be burdensome on caregivers especially those caring for patients with a critical condition.

Stajduhar, Funk, Toye, Grande, Aoun and Todd (2010) stated that “Family caregivers represent the backbone of health care and social care in countries throughout the world, including western or developed countries.” Despite this fact, most of the family caregivers lack the necessary resources to care for their loved ones properly. Some of the resources needed to help family caregivers improve their services to patients include transport, food basket and many others. According to a study by Ama and Seloilwe (2011), very little support is offered to caregivers by the private sector and communities in terms of provision of allowances for food, recreational activities and even transport to clients’ homes. This makes caregiving a challenging issue as most of the families in Botswana do not even own a car. Transport is usually needed to transport the client to and from the health facility if there is need especially for review or when there is an emergency.

In Lobatse there are about 121 people registered with the community home based care programme who present with various conditions which include but not limited to cerebral-

vascular accident, severe disability such as cerebral palsy, HIV and AIDS, psychiatric conditions, tuberculosis, cancer and others. The elderly are also amongst people on home based care programme. The age range of clients on home based care programme in Lobatse is 5 to 60 years and above, while that of caregivers range from 14 to 80 years. Clients on community home based care need help to meet their activities of daily living, a task which is performed by their next of kin who are mostly females. Some next of kin need help such as allowances for food, recreational activities and even transport to clients' homes so as to provide quality care to their loved ones. In health care system, there is shortage of skilled manpower in the area to help family caregivers.

There is only one community home based care coordinator (nurse) based at the district health management team offices responsible for the whole district of Lobatse. Lobatse has 5 clinics, a district hospital, and a large referral psychiatric hospital. The catchment area is wide, hence, makes it impossible for community home based care nurse to visit all clients in their homes to provide support. Nurses and health education assistants in clinics are also not able to conduct home visits because they are busy in the clinics. The same applies to CHBC volunteers and the social worker as they too have other commitments apart from visiting CHBC clients. This situation compromises the quality patient care.

Clients and their caregivers experience transport challenges for their reviews and follow up care as the ambulance is not always available and most families do not own cars nor can they afford to hire a cab or private car to take their patient to the hospital. Health care workers sometimes are not able to conduct home visits as desired because of unavailability of transport. A report on the evaluation of community home based care revealed that most of the vehicles provided for CHBC are available and in good condition but are not easily accessible for home visits or for home assessments by the social workers (Ministry of Health,

2009). The report further states that one needs to make a request ahead of time to the transport unit to use the vehicles.

The evaluation also reports that there is inadequate supply of necessities like toiletries, napkins (diapers), disinfectants, gloves and food rations which are often not enough to last a whole month as some patients rely entirely on that (Ministry of Health, 2009). All these challenges make family caregiving very difficult and stressful. The occasional shortage of napkins is attributed to lack of transportation to collect supplies especially at the national level. The report further states that complaints regarding types and quality of food basket were few and far between while the question of amount of food was persistent. It was also revealed that both clients and caregivers valued food more than other supplies hence they recommended an increase in food rations (Ministry of Health, 2009).

Most family caregivers do not have training on how to care for their loved ones at home. Most of them do not even know about the existence of the home based care policy therefore they end up suffering in silence not knowing where to find help. The Ministry of Health (2009) report revealed that availability of information, education and communication (IEC) materials on CHBC in most districts is limited. The report further revealed that where IEC was available, it was not displayed in easily noticeable areas.

1.3 Objectives of the study

The main goal of this study is to investigate the challenges faced by family caregivers when providing care to clients in the home settings in Lobatse.

Specific objectives

- To investigate the challenges faced by family caregivers in providing care in the home setting.

- To investigate the types of support offered to family caregivers.
- To make recommendations to improve service delivery in CHBC and to influence CHBC policy.

1.4 Justification

In Botswana, several studies have been carried out to explore the challenges faced by the community home based care programme, but emphasis did not focus on challenges experienced by family caregivers. This study will create awareness among stakeholders to identify the types of support and the clients' needs. The study findings will inform CHBC policy through recommendations on how to improve support to family caregivers for better health outcomes.

Botswana's Vision 2016 requires that all its citizens should be healthy by the year 2016. Pillar number three speaks of a compassionate, just, and caring nation; which means that as a nation we should care for each other. For family caregivers to provide care effectively, the government and other stakeholders should support them.

Dahlgren (2012) observed that even though caregivers are usually poor at the beginning of their care giving work, they become poorer in the process. Similarly, Campbell and Macmillan (2012) observed that carers become poorer by supplementing home-based care kits from their own pockets, and paying for transport for themselves and their clients. This will hopefully prompt the government to increase the amount of packages supplied for the upkeep of beneficiaries especially the food basket.

The study results will also inform the social services policy of the needs of clients and their families such as nursing homes, respite care centres or day cares centres where the sick could be taken to, and allow family caregivers to rest and be able to perform other duties. Finally, I

hope this study will generate new knowledge and research questions that will bring out new solutions to improve CHBC in Botswana. Similarly, Stajduhar (2013) asserts that there is need to design studies that test promising interventions and evaluate the ones that are most effective. Such studies could provide solutions to the burdens of care that caregivers face when providing care at home.

1.5 Summary

The government's efforts in supporting family caregivers to better care for their loved ones needs to be improved as it is apparent that it is not enough. Donor organizations need to complement the package issued by government in order to ease the burden of caring on family caregivers. Community home based care programme can only be sustained if all stakeholders take it as a necessity that needs to be natured.

1.6 Definition of Terms

The following terms are consistently used throughout the study and they should be understood to mean the following:

Community Home Based Care: Care given to individuals and their families in their home environment with the family playing a pivotal role, supported by skilled health, social workers and the community at large (Ministry of Health 2012).

Community care: Care that patients receive from community health workers, neighbours or volunteers and care providers connected to programmes supported by government, non-governmental organizations (NGOs), churches or other civil society organisations (Isaacs, Mundeta & Masunda, 2010).

Home care: Care that patients receive in their homes from relatives, friends and other members of the household which includes physical, psychological, palliative and spiritual activities. (Isaacs, Mundeta & Masunda, 2010).

Volunteering: The commitment of time and energy for the benefit of society and the community. It is undertaken freely and by choice, without concern for financial gain (Isaacs, Mundeta & Masunda 2010).

Family caregivers: A family caregiver is someone who is responsible for attending to the daily needs of another person (Hunt & Watson, 2010).

Caregiving: The action/process of helping those who are suffering (Hermanns & Mastel-Smith, 2012).

Chapter 2.0: Literature Review

2.1 Introduction

This chapter presents literature on family caregiving locally, regionally and internationally. One of the specific objectives of this study is to investigate the challenges faced by family caregivers in providing care in the home setting. Some of the challenges faced by family caregivers in Lobatse include financial burden, lack of training and gender imbalance in caregiving. Caregivers have various needs depending on the types of clients they have, family support system and the economic status of the family.

From the literature, there is evidence that Community home based care has positive impact on people who are chronically or terminally ill and need assistance with activities of daily living. Cataldo, Musheke, Kielmann, Mburu and South (2010) and Pindani et al (2013) found that there are challenges experienced by caregivers despite the positive results of community home based care. There is no doubt that Botswana like other African countries has benefited from the community home based care programme especially to people living with HIV/AIDS and other debilitating conditions. Although caregivers are not professionals, they provide a critical service to their loved ones, even though they have limited knowledge on counselling, health education, nutrition, monitoring and psychological support. Unlike health care workers, family caregivers are “on call” 24 hours a day (Tichauya, 2012).

According to Reinhard, Levine and Samis (2012) family caregivers traditionally provided assistance with bathing, dressing, eating, and household chores such as shopping and managing finances. The authors further argue that the services provided by family caregivers remain critically important to the well-being of care recipients, and that the role of family caregivers has dramatically expanded to include performing complex medical or nursing tasks once provided only in hospitals. Nelson and Yadrach (2013) observed that having a

family member with complex medical needs has an impact on the health and wellbeing of the entire family. The authors argue that the events from one stage of life influence later stages calling for the need to provide appropriate and timely family support and resources.

Dahlgren (2012) stated that the next-of-kin takes on the increased burden of providing care to their sick relatives in the midst of lack of supportive structures for both the sick persons and their caregivers. A study carried out in Canada by Ducharme (2014) reported that family caregivers are increasingly considered an at risk clientele within the health care system and their quality of life (QoL) has come to depend on professional support in the form of educational interventions, counselling, and respite services. The studies show that the kinds of support needed by family caregivers to perform their duties adequately and provide quality care are varied. These support services include finances, transport services, food baskets, training, psychosocial, respite and gender balance in care. Cataldo et al (2010) observed that lack of support services could lead to demotivation of caregivers.

2.2 Financial Burden

The issue of finances is the most prominent of all challenges experienced by family caregivers (Kathuri-Ogola, Mugenda & Kerre 2014; Woldie & Morankar 2013; Wu 2009). According to Ama and Seloilwe (2010), even though CHBC is seen as a cheap alternative mode of delivering care, families and caregivers do not afford it. The authors state that families are struggling to make ends meet. This is due to the fact that most of the family caregivers are unemployed or the person being cared for is the bread winner. In another study in Botswana, Mmopelwa et al (2012) reported that some family caregivers had given up jobs so as to provide care to loved ones leaving them without any cash income to sustain themselves and the rest of the family. The authors further argued that out of pocket costs and being without cash income all add up to the burden of caregiving. In Canada, Duxbury,

Higgins and Schroeder (2009) found out that family caregivers with limited financial resources experience financial strain while it is not the same for those who have resources.

In Botswana, most households are poor such that they cannot afford to hire somebody else to look after their loved ones for them to rest. The situation is made worse by the fact that there are very few respite care services where family caregivers can take their relatives to during the day so that they can have temporary relief from caregiving duties. The few that are available are in Gaborone, the capital city. Two of the day care centres are run by faith-based organizations while one is operated by the Gaborone City Council. These centres can only accommodate 10 clients or less per day. Clientele include the aged/elderly, people with disabilities, chronic illness and others during the day.

In India, Narasipuram and Kasimahanti (2012) advocated for the establishment of respite homes for care receivers and residential care for either short term or long-term for caregivers to have some time for themselves. Barber (2013) stated that the purpose of respite programs is to periodically or temporarily relieve family caregivers from the continuous responsibility of providing day-to-day care for one or more elderly family members. The rest afforded by respite care offers family caregivers time to be alone, to carry out other activities, or respond to other obligations. In Taiwan, Wu (2009) reported that family caregivers are able to hire a helper to relieve them from their caregiving responsibilities.

2.3 Lack of Training

Lack of training of family caregivers is one of the challenges that defeats the efforts of community home based care programme because caregivers need all the support they can get from professional carers to provide quality care to their clients. Without the help of health care providers, family caregivers provide care with little information rendering them

ineffective. The lack of training of caregivers also serves as a risk factor in terms of preventing and controlling transmission of infection.

In a study in Botswana, Dahlgren (2012) reported that caregivers are not properly informed and trained in the handling of patients especially those with communicable diseases to reduce the risk of infections. This is because some of the clients suffer from conditions that are easily transmissible like Tuberculosis and HIV and AIDS placing a less knowledgeable family caregiver at risk of contracting the disease. Someone who lacks knowledge needs to be taught to take precautions so that she or he does not contract the disease or spread it to other people especially if caring for more than one patient. This is something that could be avoided with regular visits by health care workers as they are knowledgeable and could educate the caregivers on precautions to take to prevent transmission of infections. A study carried out in Lesotho reported that caregivers generally experience stress as well as being vulnerable to infection. The study also stated that the problem is being exacerbated by the lack of adequate training, mentoring and support (Newman, Makoae, Reavely & Fogarty, 2009).

Dahlgren (2012) also reported that in Botswana, there is lack of proper systems of accessing information for people in need of social services due to the fact that the only way of accessing this information is through contact with clinics, hospitals and the police. Some of the caregivers in Lobatse are not aware that information on social services is available at the clinics, hospitals and the police and therefore do not report their needs to any of those places. Sterling (2014) states that family caregivers need the right information at the right time in order to be effective health managers. According to a cross-sectional study conducted in Tanzania, Malale (2011) observed that the majority of family caregivers had inadequate knowledge, good attitude and practice of the home care provision. The author observed that

trained family caregivers were more knowledgeable, have better attitude and practice of home care.

Glajchen (2012) asserts that information can help normalize caregiver experience and enhance a sense of control on what to expect during the illness course. In a study in the United States, Robinson (2014) reported that the clinical atmosphere is rushed such that family preparation for caregiving responsibility is reduced to the provision of booklets or the sharing of a video. The author further observed that most of the time, the family is left feeling anxious with a lot of unanswered questions leading to frustration. This calls for health care workers to take their time when giving information about caregiving to relatives to make sure that they have understood. The family caregiver should also be encouraged to ask questions for clarification to prevent frustration.

2.4 Gender imbalance

Amongst the challenges faced by family caregivers in Botswana is the issue of gender imbalance in family caregiving. Kang'ethe (2010) observed that most caregiving environments especially in developing countries tax girl children while boy children are excused from caregiving by culture and socialization. Another study by Isaacs, Mundeta and Masunda (2010) revealed that the feminisation of TB, HIV and AIDS has resulted in women and girls bearing the burden of infection, care and support. Similarly, Dahlgren (2012) observed that caregiving work takes up women's time, as they have to stay close to the sick person, to feed, bathe, and wash their clothes. In certain cases the sick person cannot even stand up to get water for themselves so the constant need of a helper keeps women in the home. Despite the difficulty of caregiving, all caregivers look at it as a role that only a woman can do.

In Lesotho, Newman, Fogarty, Makoae and Reavely (2011) reported a nexus of gender stereotypes and status beliefs related to men and women, perceptions of their natural roles, and related social expectations and sanctions that kept women in voluntary HIV and AIDS caregiving and kept men out of it. In a study to assess male involvement in community home based care in Namibia, Campbell and Macmillan (2012) found that male care providers made up less than 20% of all caregivers in the area. In Canada, the majority of women make up 77% of all family caregivers (Stajduhar, 2013). Similarly, in America, Hunt & Watson (2010) also observed that the majority of family caregivers are women (66%). The authors further assert that caregiving remain largely a woman's responsibility. Research indicates that women's role in family caregiving is not unique to Botswana and the rest of Africa.

2.5 Support services

While CHBC may be seen as a cheap alternative mode of health care delivery, it is certainly not affordable for families and caregivers (Ama & Seloilwe, 2010). In Botswana, the government makes efforts to provide necessary services to the beneficiaries, but these services are not adequate and access to these services remains a challenge to most caregivers. Dahlgren (2012) observed that despite the transfer of care responsibilities from the health care system, to the next-of-kin, the Botswana government has failed to build pronounced support systems for caregivers in terms of psychological and practical resources that will sustain them in their work. This is one of the things making caregiving very difficult or stressful.

It is not only in Botswana where support for home based care clients is not enough. According to a study in Ethiopia, support activities available for home based care clients are not adequate and not well organised (Zerfu, Yaya, Dagne, Deribe, Escuredo, Biadgilign

2012). The study listed some of the support services needed by clients on home based care as food, training of family caregivers, psychosocial support and others.

2.6 Summary

There is evidence that family caregivers are at the core of community home based care. However, caregivers still receive inadequate support from the government and donor agencies. Several studies have made some recommendations to improve the quality of community home based care services for people in need. There is need to increase support to caregivers, by drawing up policies that acknowledge the importance of family caregiving to improve services in home care settings. Policies should address the issue of respite care for caregivers and clients if community home based care programme is to deliver quality care. Studies have also recommended that nurses and other medical personnel should get more involved in the community home based care programme through regular visits to clients in their homes to observe the state of their health and supervise family caregivers.

Policies should also address the issue of gender inequality to encourage sharing of the burden of care for loved ones. The public should be educated about the importance of male involvement in family caregiving. Some authors have recommended that nursing homes or respite care centres be built so as to provide respite to family caregivers, something that is long overdue in our country.

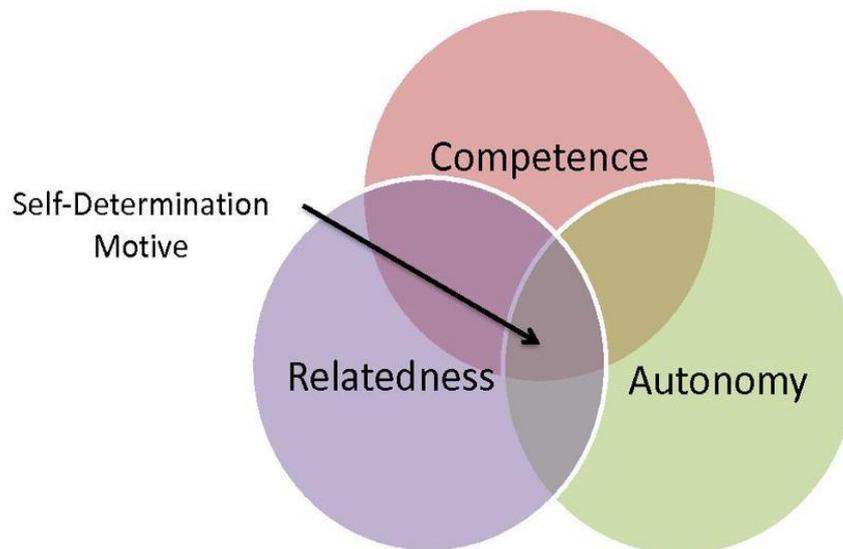
More importantly caregivers should be provided with continued training to enhance their care giving skills to improve the quality of care. There is also need for a standardised curriculum to train family caregivers and health workers on CHBC. Governments, external donors and other stakeholders are called up to provide financial and material support to the CHBC program.

2.7 Theoretical Framework

This study will be guided by the Self Determination Theory (SDT) (Deci & Ryan, 2008). This is a macro theory of human motivation that addresses basic issues such as personality development, self-regulation, universal psychological needs, life goals and aspirations, energy and vitality, non-conscious processes, the relations of culture to motivation, and the impact of social environments on motivation, affect, behaviour, and wellbeing. Self Determination Theory has been applied to issues within a wide range of life domains including health care, sport, and education (Deci & Ryan, 2008).

According to SDT, people have three innate psychological needs considered as universal necessities. These three basic psychological needs are competence, relatedness and autonomy. The need for competence means the desire to control and master the environment and outcome (Deci & Ryan, 2008). The need for relatedness deals with the desire to interact with, be connected to and experience caring for other people (Deci & Ryan, 2008). Deci and Ryan (2008) also stated that the need for autonomy concerns with the urge to be causal agents and to act in harmony with their integrated self. According to Deci and Ryan (2008), to be autonomous does not mean to be independent but having a sense of free will when doing something.

Three Innate Psychological Needs Comprise The Self-Determination Theory of Student Motivation



Source: Deci, E.L., & Ryan, R.M. (2000). The "What" and "Why" of goal pursuits: Human needs and the self-determination of behaviour. *Psychological Inquiry*, 11, 227-268.

Motivation is another part of self-determination theory. According to Deci and Ryan (2008) SDT asserts that there are different approaches to motivation. The most central distinction in SDT is between autonomous motivation and controlled motivation. The authors further stated that autonomous motivation comprises both intrinsic motivation and the types of extrinsic motivation in which people have identified with an activity's value and ideally will have integrated it into their sense of self. They further asserted that when people are autonomously motivated, they experience volition, or a self-endorsement of their actions.

The authors stated that controlled motivation, in contrast, consists of both external regulation, in which one's behaviour is a function of external contingencies of reward or punishment,

and introjected regulation, in which the regulation of action has been partially internalized and is energized by factors such as an approval motive, avoidance of shame, contingent self-esteem, and ego-involvements. Deci and Ryan (2008) argued that when people are controlled, they experience pressure to think, feel, or behave in particular ways. Both autonomous and controlled motivations energize and direct behaviour. One can then say that these two types of motivations both contribute to family caregivers' efforts of caring for needy loved ones without being forced to do so.

2.7.1 Application of the Framework

Self-determination theory can be useful in understanding the reason behind the perseverance of family caregivers in caring for their loved ones despite challenges they encounter. The two parts of the theory are applicable to concept of caregiving. According to the theory, people have three innate psychological needs considered as universal necessities namely competence, relatedness and autonomy (Deci & Ryan, 2008). The need for competence is evident in family caregivers as they want to control the outcome of their loved ones conditions by caring for them effectively. Family caregivers also exhibit the need for relatedness as they feel connected to their loved ones when taking care of them. Caregiving provides an opportunity to experience how it feels like to care for a loved one hence the ability to continue caring for relatives without being coerced to do so. Family caregivers also act out of own interests when caring for their loved ones despite the challenges they encounter.

The second part of the theory is the distinction between autonomous and controlled motivation (Deci & Ryan, 2008). Family caregivers are autonomously motivated thus they care for loved ones out of necessity or obligation. The authors stated that controlled motivation, in contrast, consists of both external regulation, in which one's behaviour is a

function of external contingencies of reward or punishment, and introjected regulation, in which the regulation of action has been partially internalized and is energized by factors such as an approval motive, avoidance of shame, contingent self-esteem, and ego-involvements (Deci & Ryan, 2008). These two types of motivation both contribute to family caregivers' efforts of caring for needy loved ones without being forced to do so despite challenges. The self-determination theory has been utilized as a framework in health related studies. One example is a meta-analysis of data sets from studies that utilized self-determination theory in health care and health promotion contexts by Johan, Ntoumanis, Thøgersen-Ntoumani, Deci, Ryan, Duda and Williams (2012). The results of the Meta analysis showed SDT to be a viable conceptual framework for studying the outcomes of motivation for health-related behaviours.

Chapter 3.0: Methodology

3.1 Introduction

This chapter presents the study design, setting, ethical considerations, sampling, data collection instruments, data analysis and establishment of rigor.

3.2 Study Design

According to Burns and Grove (2011), a study design is a blueprint for conducting a study with a purpose of maximising control over factors that can interfere with validity of study findings. Qualitative research design will be used in this study. The study is exploratory and descriptive in nature. According to Elmusharaf (2012) “the aim of qualitative research is to understand, from within, the subjective reality of the study participants. The study design was chosen because of its ability to obtain a lot of in-depth information from people (Elmusharaf 2013). This study investigates challenges faced by family caregivers while providing care to their sick relatives in their homes.

3.3 Study setting

The study will be carried out in the town of Lobatse in the southern part of Botswana within a period of six months. Lobatse has a population of 29,007 (2011 Botswana Population and Housing census, 2012), and was selected because it is the biggest town in the southern part of the country with people migrating into it in search of jobs thus leaving their support systems (family members) behind. Lobatse was also selected because the researcher has had the opportunity to interact with family caregivers in their homes during home visits and observed that they were struggling to make ends meet.

3.4 Sampling

Purposive sampling will be used to recruit family caregivers into the study. According to Burns and Grove (2011) purposive sampling involves conscious selection of certain participants, elements, events or incidents to include in the study. In this study, a list of all family caregivers will be obtained from the health clinics in Lobatse after which they will be invited to participate. Invitation will be through a letter written by the researcher and hand delivered to the chosen participants' homes (family caregivers) and place of work (health care providers). An informed consent form will then be given to those who agree to participate in the study to familiarise themselves with its contents. There will be 22 participants in the study. Participants will comprise of the Social worker, Community home based care coordinator (Nurse), one nurse and one health education assistant from each of the five clinics, one CHBC volunteer from each clinic and one family caregiver from each of the five areas around clinics.

3.4.1 Inclusion criteria

- Participants who are at that time of data collection have been caring for a family member for at least six months or more will be selected.
- Participants should be primary caregivers of clients registered with the community home based care programme.
- Health care providers such as Community home based care coordinator, community health nurses, social worker, CHBC volunteers and health care assistants (former family welfare educators) involved in the care of CHBC clients will also be included.

3.4.2 Exclusion criteria

- Health care providers who are not involved with community home based care clients will be excluded from the study.
- Family caregivers who have been caring for their relatives for less than six months and those caring for clients who are not registered with community home based care programme will also be excluded from the study.
- Another group of people who will be excluded from the study are family caregivers who are not primary caregivers or who occasionally care for CHBC clients.

3.5 Ethical Consideration

Ethical issues arise due to the need to do good for the client and to avoid harm (Speziale & Carpenter, 2007). Permission to carry out the study will be sought from the University of Botswana institutional review board (IRB) and the Health Research Development Committee of the Ministry of Health in Gaborone. Permission to carry out the study will also be sought from individual participants. The purpose of the study will be explained to the participants prior to their enrolment into the study or prior to the signing of a consent form. To ensure anonymity, codes will be used instead of names. Individual consent for audio taping will be sought. If any participant refuses to be audio tape recorded, the researcher will only take notes.

In order to ensure confidentiality, a separate document that links the study codes to subjects' identifying information will be locked in a separate location and access to this document will be restricted to all, but will be accessible to the primary investigator and only the research assistant. Data will be securely stored within locked locations in a password protected computer. Participants will be informed that the interview will take an hour or less.

Participation in this study is voluntary and respondents are free to withdraw from the study at any time without penalties.

3.6 Data Collection

Two interview guides developed by the researcher and based on the theoretical framework of the proposed study will be used to collect data. The researcher and a research assistant will be involved in data collection. A research assistant will be recruited and trained for a day on data collection tool and research process. There will be two different interview guides: one for the health care providers and another for family caregivers. Bhattacharjee (2012) indicates that interviews may be of different types for example, telephone, personal or face to face, intercept and focus group. In this study, face-to-face indepth interviews will be conducted and data will be audio taped and transcribed. An advantage for conducting face to face indepth interviews is that skilled interviewers can persuade participants to cooperate, dramatically improving response rates (Bhattacharjee 2012). Data will also be collected by observation of participants' daily activities. The data will be collected in Lobatse town in the southern part of Botswana.

The interview guides will be pilot tested before use in Otse village among family caregivers and health care workers with similar characteristics to those in the main study. About three participants will be used to pilot test each interview guide. Burns and Grove (2011) described a pilot study as a smaller version of a proposed study which is conducted to refine methodology. The results of the pilot study will be used to refine the data collection tools so that they are ready for use when the study begins.

3.7 Data Analysis

Data analysis will occur simultaneously with data collection to enable the research process to capture all potentially relevant aspects of the topic as soon as they are observed. The researcher will use the grounded theory analysis approach. Polit and Beck (2014) defines grounded theory as an approach to collecting and analysing qualitative data that aims to develop theories about social psychological processes grounded in real-world observations. The rationale behind choosing it is because it is regarded as comprising solid and organized guidelines which helps novice researchers in their investigations. The theory is also appropriate for the realistic approach to nursing practice.

Grounded theory analysis approach involves three coding techniques/phases for analysing text data. The first phase is open coding. Data will be broken down into parts and compared for similarities and differences. Similar actions, events and objects will be grouped together as more abstract concepts called categories.

The second phase of coding is axial. Categories will be linked with subcategories to come up with hypotheses that can tentatively explain the phenomenon of interest. Selective coding is the third phase of grounded theory where findings will be integrated and refined. The core category/main pattern will be identified or decided upon and systematically and logically related to other categories. The core category will be identified by writing the storyline using diagrams and reviewing and organising memos. New data will be selectively sampled to validate or refine the core category or its relationship to other categories. The result will be a full conceptual description.

3.8 Establishment of Rigor

Strategies to help establish credibility, dependability, transferability and confirmability of the findings would be employed.

3.8.1 Credibility

Elmusharaf (2013) defines credibility as the ability of the study to capture what the researcher really aimed at studying. To ensure credibility for this study, the researcher will have prolonged engagement with study participants so as to establish trust and rapport with study participants. The researcher will also observe participants as they go about their daily lives to make sure that he or she observes any changes in their way of life. Audio tapes will be used to capture all the information for accuracy. Peer debriefing and member checks will also be employed to establish credibility. A three panel expert in qualitative research will be asked to review and explore various aspects of the enquiry by asking the researchers some questions. These experienced peers will be colleagues who have completed their research. Member checks will be carried out during data collection to solicit study participants reactions to preliminary findings and interpretations.

3.8.2 Dependability

According to Polit and Beck (2014) dependability refers to data stability over time and over conditions. Collier-Reed, Ingerman and Berglund (2009) stated that care must be exercised during interview conversation and during transcription of data. Coding of the data obtained will be done by the researcher and the assistant after that they will compare their categorisations. An external reviewer will also scrutinise the data and relevant supporting documents to enhance dependability.

3.8.3 Transferability

Transferability is the extent to which qualitative findings can be transferred to or have applicability in other settings or groups and is similar to the concept of generalizability (Polit & Beck, 2014). To ensure transferability, the researcher will provide sufficient descriptive data in the research report to allow consumers to evaluate applicability of the data to other contexts. The researcher will describe the research setting, transactions and processes observed during data collection (Polit & Beck, 2014)

3.8.4 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. It is concerned with establishing that data represent the information that participants provided and that the interpretations of data are not imagined by the enquirer (Polit & Beck, 2014). The researcher will ensure confirmability by availing the audit trail materials such as raw data, data reduction and analysis products, process notes, materials relating to intentions and dispositions, instrument development information and data reconstruction products to the inquiry auditor. This will be someone who is knowledgeable in the field of research and has published several researches before. The researcher will share decision trail information in the research report so as to help readers to be able to evaluate the soundness of the decisions and make conclusions regarding the study trustworthiness.

3.8.5 Summary

The methodology chosen for the proposed study is appropriate to uncover the challenges faced by family caregivers. The study design and sampling method are also appropriate as the researcher will have the opportunity to observe and interact directly with participants who

have first-hand information as they are involved in care of clients. It will also be easier and faster to analyse data as analysis will occur simultaneously with data collection. Rigor will also be ensured by checking for credibility, dependability, transferability and Confirmability.

Research Management Plan

	Task Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
		19-31	01-28	01-31	01-30	01-31	01-30	01-31	01-31	01-30	01-31	01-30	01-20
1	Proposal writing												
2	Submit for approval												
3	Recruiting assistant, participants												
4	Pilot instruments												
5	Data collection												
6	Data collection												
7	Data collection												
8	Data collection												
9	Data analysis Report writing												
10	Disseminate findings												

Research Budget

The research budget presents the equipment and estimated cost of the study. The materials to be used in the study, trips to and from the place of study and the airtime for communication to appoint with participants for interviews should be budgeted for. This is done for funding purposes.

Equipment to be used	Total Cost
A rim of printing paper @ P50 X 2	P100
A box of pens @ P45 X 1	P45
A packet of CDs (10's) @ P50 X 1	P50
Airtime @ P100 X 10	P1000
Printing @ P50 X 1 copy	P50
Photocopying @ P1 x 43pages x 5 copies	P215
Public transport: June and July 2015	
5 return trips from Lobatse to Otse @ P10 per person x 1 return trip x 2 people	P100
Lunch @ P67.50/day x 2 people x 75 days	P10125.00
Local transport within Lobatse	
-data collection	
1 return trip per day/person x 2 @ P8/ trip x 3 weeks per clinic = 15 working days per clinic x 5 clinics: 75days x P16	P1200
	TOTAL: P12885.00

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APPENDICES

APPENDIX 1: Permission letter

University of Botswana
Private Bag 0022
Gaborone
01 June 2016

Health Research Development Committee
Ministry of Health
Private Bag 0038
Gaborone

ATT: The Chairperson

Dear Sir/Madam

RE: Request for permission to conduct a study on community home based care.

My name is Keiponye Sebogodi and I am writing to seek permission to conduct a study in Lobatse (health clinics). I am a student at the University of Botswana reading for Master of Nursing Science Degree in Community Health Nursing. This study is in partial fulfilment of the Masters degree. The study seeks to investigate the “Challenges faced by Family care givers who provide care to clients in the home settings in Lobatse.”

Study objectives are to: (i) investigate the challenges faced by family care givers providing care in home settings, (ii) investigate the types of support offered to family care givers, and, (iii) make recommendations to address the challenges faced by the family caregivers.

I am therefore seeking your permission to allow me to interview the community home based care coordinator, community health nurses, health education assistants, social workers, CHBC volunteers and family caregivers in Lobatse. The study will be conducted in June 2016.

I look forward to your favourable response.

Yours Sincerely

Keiponye Sebogodi

Cell NO: 71823575/Email: skeiponye@gmail.com

APPENDIX 2: Informed Consent Form

PROJECT TITLE: Challenges faced by Family caregivers in the home settings in Lobatse

Principal Investigator: Keiponye Sebogodi, University of Botswana Master of Nursing Science Student

Phone number(s): 71823575

What you should know about this research study:

- We give you this informed consent document so that you may read about the study purpose, risks, and benefits.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation in the study is voluntary.

PURPOSE

You are being asked to participate in a research study of “Challenges faced by family caregivers in the home settings in Lobatse.” The purpose of the study is to investigate the challenges faced by family caregivers when providing care to clients in the home settings in Lobatse. You were selected as a possible participant in this study because you were identified as a family caregiver or a health care provider. Before you sign this form, please feel free to ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

PROCEDURES AND DURATION

If you decide to participate, you will be invited to an interview that may take up to an hour. The interview will be audio taped. In case you do not want to be audio taped, you are free to say so and the interviewer will take notes.

RISKS AND DISCOMFORTS

During the interview you may feel uncomfortable to answer some questions. If you feel as such you are free to decline to answer such questions or to end the interview.

BENEFITS AND/OR COMPENSATION

There will be no payment for participating in the study.

CONFIDENTIALITY

The researcher will not identify you by name in any reports using information obtained from the interviews. Your confidentiality as a participant in this study will remain secure. No

information will be divulged to anyone not involved in the study and data will be locked in a safe place only accessible to the researcher. Subsequent use of records and data will be subject to standard data use policies which protect anonymity of individuals.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the University of Botswana, its personnel, and associated institutions. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. Any refusal to observe and meet appointments agreed upon with the primary investigator will be considered as implicit withdrawal and therefore will terminate the subject's participation in the investigation without his/her prior request. In the event of incapacity to fulfil the duties agreed upon the subject's participation to this investigation will be terminated without his/her consent.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Name of Research Participant (please print)	Date

Signature of Researcher Obtaining Consent	Date

(Optional)

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Office of Research and Development, University of Botswana, Phone: Ms Dimpho Njadingwe on 355-2900, E-mail: research@mopipi.ub.bw, Telefax: [0267] 395-7573. Ministry of Health, Phone: Mr Pilate Khulumani on 3632775, E-mail: dfmmorimi@gov.bw, Telefax: [0267] 3910647.

Setswana Version

APPENDIX 3: Mokwalo wa tetla

SETLHOGO SA TSHEKATSHEKO: Dikgwetlho tse di lebanyeng batlhokomedi(masika)
ba balwetsi mo malwapeng mo Lobatse

Mosekaseki Mogolo: Keiponye Sebogodi, University of Botswana Master of Nursing
Science Student

Mogala: 71823575

Se o tshwanetseng go se itse ka tshekatsheko e:

- Re go neela pampitshana e ya tetla gore o bale ka maikaelelo, borai le mosola wa tshekatsheko.
- O na le tshwanelo ya go gana go tsaya karolo, kana go dumela go tsaya karolo mme ere morago o fetoge.
- Tswee tswée, sekaseka mokwalo o wa tetla sentle. Botsa dipotso pele o tsaya tshwetso.
- Go tsaya karolo mo patlisisong e ke boitlhaopo.

MAIKAELELO

O kopiwa go tsaya karolo mo tshekatshekong ya “dikgwetlho tse di lebanyeng batlhokomedi ba masika ba balwetsi mo malwapeng mo Lobatse.” Maikaelelo a tshekatsheko ke go batlisisa dikgwetlho tse di lebanyeng batlhokomedi ba masika fa ba tlhokometse balwetsi mo malwapeng mo Lobatse. O tlhophilwe go nna motsaya karolo mo tshekatshekong e ka gore o lemogilwe o le motlhokomedi wa molwetsi/balwetsi ba losika kgotsa modiredi wa botsogo. Pele o baya monwana pampitshana e, tswée tswée, gololesega go botsa potso nngwe le nngwe mabapi le ntlha nngwe le nngwe ya patlisiso e, e e sa tlhatswegang mo go wena. O ka tsaya nako e o e tlhokang go ikakanya.

DITSAMAISO LE SEBAKA

Fa o tsaya tshwetso ya go tsaya karolo, o tla lalediwa potsolotso e e ka nnang ya tsaya sebaka sa oura. Potsolotso e tla kapiwa ka sekapa mantswe. Fa o sa batle go kapiwa lentswe, o gololesegile go bua jalo, mmotsolotsi o tla tsaya metsotso.

BORAI LE TLHOKO IKETLO

Ka nako ya potsolotso, o ka nna wa ikutlwa o sa gololesega go araba dipotso dingwe. Fa o ka ikutlwa jalo, o gololesegile go gana go araba dipotso dingwe kana o ka emisa potsolotso.

DIPOELO KGOTSA TUELO

Ga gona go nna le tuelo ya go tsaya karolo mo patlisisong e.

SEPHIRI

Mosekaseki ga ana go go senola ka leina mo dipegong dipe a dirisa mafoko a a tswang mo dipotsolotsong. Sephiri sa gago jaaka motsaya karolo mo tshekatshekong e se tla babalesega. Ga gona mafoko ape a a tla bolelelwang ope yo o seng bontlha bongwe jwa tshekatsheko e, gape mantswa/mekwalo e tla bewa mo lefelong le le babalesegileng ebile mosekaseki ke ene fela a ka kgonang go bala/reetsa mekwalo/mafoko a. Tiriso gape ya mekwalo kgotsa mafoko e tla sala morago melawana ya tiriso e e sireletsang go sa itseweng ga batsaya karolo.

ITLHAOPO GO TSAYA KAROLO

Go tsaya karolo mo tshekatshekong e ke boitlhaopo. Fa o ka gana go tsaya karolo mo tshekatshekong e, tshwetso ya gago ga e na go ama botsalano jwa gago jwa isago le University ya Botswana, babereki ba yone le makalana a a dirisanang nayo. Fa o tsaya tshwetso ya go tsaya karolo, o gololesegile go boela morago tetla ya gago le go emisa go tsaya karolo nako nngwe le nngwe o sa otlhaiwe ka gope. Fa o gana go tlotla nako ya bokopano le mosekaseki mogolo, go tla tsewa gore o ikgogetse morago mo tshekatshekong mme go tsaya karolo ya gago go fedisiwe kwa ntle le go kopa seo. Fa go ka diragala gore motsaya karolo a palelwe ke go fitlhelela ditirelo tse go ne go dumalanywe ka tsone, go tsaya karolo ga gagwe mo tshekatshekong go tla emisiwa ntle le tetla ya gagwe.

THEBOLO

O tsaya tshwetso gore o tsaya karolo mo patlisisong e kana nnyaa. Peo monwana wa gago e supa gore o badile ebile o tthaloganya molaetsa o o filweng fa godimo, dipotso tsa gago tsotlhe di arabilwe ebile o tsere tshwetso ya go tsaya karolo.

Leina la Motsaya karolo (Kwala go bonala)

Letsatsi

Monwana wa mosekaseki yo o kopang tetla
(Ga e patelediwe)

Letsatsi

O TLA FIWA MORITI WA PAMPITSHANA E YA TETLA GO O IPOLOKELA

Fa o nale dipotso dingwe mabapi le patlisiso e kana pampitshana ya tetla kwa ntle ga tse di arabilweng ke mmatlisisi, go akarediwa dipotso mabapi le patlisiso, ditshwanelo tsa gago jaaka motsaya karolo mo patlisisong; kana o ikutlwa o sa tsewa sentle mme o batla go bua le mongwe kwa ntle ga mongwe wa babatlisisi, tswee tswee gololesega go leletsa ba kantoro ya dipatlisiso le ditlhabololo, University ya Botswana, Mogala: Ms Dimpho Njadingwe mo 355-2900, E-mail: research@mopipi.ub.bw, Telefax: [0267] 395-7573. Ministry of Health, Mogala: Mr Pilate Khulumani mo 363-2775, E-mail: dfmmorimi@gov.bw, Telfax: [0267] 391-0647.

Appendix 4: DATA COLLECTION INTERVIEW GUIDE (CHBC coordinator, Community Health Nurse, Social Worker, Health Education Assistant, CHBC volunteers)

1. How old are you?
2. Where do you stay?
3. What is your educational qualification?
4. How long have you been working with home based care clients?
5. What kinds of patients are registered with Home based care programme?
6. Explain the strategy that is being used to recruit/identify patients for registration into home based care programme
7. How many patients are currently registered with the programme to date?
8. Can you describe the kind of collaboration between your departments, other government departments and non- government organizations towards patients and family caregivers support?
9. When last did you or your colleagues visit home based care clients?
10. What are the clients' needs in the home settings?
11. What specific challenges do caregivers face in the home setting?
12. What do you think should be done to tackle these challenges?
13. Can you describe the kind of assistance available to family caregivers and patients enrolled in home based care programme from government and other stakeholders?
14. What are the challenges experienced in implementing the programme?
15. What are you doing to overcome the challenges encountered?
16. Any last comments/questions?

THANK YOU FOR YOUR PARTICIPATION AND TIME

Setswana Version

APPENDIX 5: Pampitshana ya dipotso (moitlhaopi/Mooki/mogolwane wa tsa tlhokomelo balwetsi mo malwapeng, Mma Boipelego, Mma dithuto tsa malwapa)

1. O dingwaga di kae?
2. O nna kae?
3. O tsene sekolo go felela fa kae?
4. O na le lobaka lo lo kae o ntse o bereka le balwetsi ba ba mo malwapeng?
5. Nankola mefuta ya balwetse ba ba kwadisitsweng mo bukaneng ya tlhokomelo balwetse mo malwapeng?
6. Tlhalosa ka fa lo dirang ka teng go ngoka balwetsi gore ba kwadisiwe mo bukaneng ya tlhokomelo balwetsi mo malwapeng?
7. Go na le balwetse ba le kae mo bukeng ya tlhokomelo balwetsi mo malwapeng?
8. O ka tlhalosa mofuta wa tirisano fa gare ga lephata la lona le a mangwe a puso le a eseng a puso mabapi le thuso ya balwetsi le batlhokomedi ba bone?
9. Lo le badiri ba botsogo, lo etetse balwetsi ba ba mo malwapeng leng la bofelo?
10. Balwetsi ba ba tlhokomelelwang mo malwapeng ba tlhoka eng?
11. Ke dife dikgwetlho tse batlhokomedi ba balwetsi ba mo lwapeng ba di itemogetseng?
12. O akanya go ka dirwang go lwantsha dikgwetlho tse?
13. O ka nankola thuso e batlhokomedi ba balwetsi le balwetsi ba ba tlhokomelelwang mo malwapeng ba e bonang go tswa mo pusong le makalana a mangwe fela a eseng a puso?
14. Lo itemogetse dikgwetlho dife mo lekalaneng le la tlhokomelo balwetsi mo lwapeng?
15. Lo dira eng go lwantsha dikgwetlho tse lo di itemogetseng?
16. Kakgelo/potso ya gago ya bofelo?

KE LEBOGELA NAKO LE GO TSAYA KAROLO GA GAGO

APPENDIX 6: DATA COLLECTION INTERVIEW GUIDE (Family caregivers of Patients registered in CHBC)

1. How old are you?
2. Where do you stay?
3. What are your educational qualifications?
4. Are you the primary caregiver? Yes/No
5. If no, who is the primary caregiver?
6. How many clients are you caring for?
7. What motivates you to care for CHBC client/s?
8. How long have you been caring for your client/s?
9. How long has/have your client/s been registered with the CHBC programme?
10. How did you find out that your client/s could be registered with community home based care programme?
11. When last did a health care worker visit your client/s?
12. When last did your client/s receive supplies from government or non - governmental organization?
13. Describe the kind of assistance available to your client/s from the government and non-governmental entities?
14. Describe the kind of assistance available to you as the caregiver from the government and non-governmental entities?
15. What challenges have you experienced in providing care to your client/s?
16. What have you done to overcome these challenges?
17. Any questions or comments?

THANK YOU FOR YOUR PARTICIPATION AND TIME

Setswana Version

APPENDIX 7: Pampitshana ya dipotso ya batlhokomedu ba balwetsi mo malwapeng

1. O dingwaga di kae?
2. O nna kae?
3. O tsene sekolo go felela fa kae?
4. A o motlhokomedu wa molwetsi/balwetsi? Ee/Nnyaa
5. Fa ese wena, motlhokomedu ke mang?
6. O tlhokomela balwetsi ba le kafe ka palo?
7. O rotloediwa ke eng go tlhokomela balwetsi ba mo malwapeng?
8. O na le lobaka lo lo kae o ntse o tlhokomela molwetsi/balwetsi mo lwapeng?
9. Molwetsi kgotsa balwetsi ba gago ba na le nako e e kae ba kwadisitswe mo lenaneong la tlhokomelo balwetsi mo lwapeng?
10. O itsile jang gore molwetsi kgotsa balwetsi ba gago ba ka kwadisiwa mo lenaneong la tlhokomelo balwetsi mo malwapeng?
11. Modiredi wa botsogo o etetse molwetsi/balwetsi ba gago leng la bofelo?
12. Molwetsi/balwetsi ba gago ba bonye dithuso leng go tswa ko pusong kgotsa makalana a ikemetseng la bofelo?
13. Ke efe thuso e molwetsi kgotsa balwetsi ba gago ba e amogelang go tswa mo makalaneng a puso kana makalana ape fela le fa e se a puso?
14. Kakgelo ya gago keeng mabapi le thuso e o e bonang o le motlhokomedu go tswa mo makalaneng a puso kgotsa makalana ape fela le fa e se a puso?
15. O itemogetse dikgwetlho dife mabapi le tlhokomelo ya balwetsi mo lwapeng?
16. O dirile eng go lwantsha dikgwetlho tse?
17. Dikakgelo kana dipotso?

KE LBOGELA NAKO LE GO TSAYA KAROLO GA GAGO