

THE ROLE OF INCENTIVES IN RAISING CARE-GIVING PRODUCTIVITY IN BOTSWANA CARE PROGRAMMES AS EXEMPLIFIED IN THE KANYE CARE PROGRAMME

Simon Kang'ethe

OPERATIONAL DEFINITIONS

Caregivers refers to either the primary caregivers who are the family and informal persons who take care of the sick person all the time; and community caregivers (called volunteers in Botswana) who are the Government recruited volunteer caregivers and move from one house to another to supervise and assist the primary caregivers in their care giving tasks. However, only the primary caregivers formed the research respondents.

STUDY RATIONALE

The article explores and discusses the role of awarding incentives as a strategy to raised care-giving productivity

INTRODUCTION AND BACKGROUND

Widespread concern about programme operations and the challenges faced by those involved in care giving as well as by community members prompted the researcher to carry out this research to assess various subjectively suggested ways of responding to the challenges of the programme. The fact that most caregivers and those around them raised the issue of the programme being demoralising and unappealing, while others suggested that the programme could be a dumping ground for the sick, added impetus to the research, making the researcher seriously consider investigating motivational factors and of course the demotivating factors in the programme (Kang'ethe, 2004).

The 2004 findings on care giving in Kanye (Kang'ethe, 2004), supported by other research such as that by JHPIEGO (2009) in collaboration with Botswana Ministry of Health, Mojapelo, Ditirafalo, Tau and Dohlie (2001), Jacques and Stegling (2001), and Khan and Stegling (2000), indicated that the programme faced a lot of challenges, especially of a psychosocial and motivational nature, and had to deal with complaints about the programme's effectiveness. It was therefore imperative for the researcher to assess how many of these challenges were still unaddressed and to investigate the possible effect of lack of incentives. This, he felt, was necessary because the CHBC programme was an important one, having been institutionalised by the government to act as a safety valve for the congested health facilities (NACP 30, 31, 1996; NACA, 2005).

As the AIDS epidemic continues to take toll, especially in the countries of the developing world, the health-care providers need to be working in an environment that is conducive to maintaining their spirits and morale, and be given incentives so that they can be motivated to provide a high level of care giving (Lawler, 1994). This is especially important to the informal caregivers who work as volunteer caregivers to complement and supplement government efforts in its fight to halt the epidemic. Many countries, Botswana included, are party to the 2001 Global United National General Assembly Special Session (UNGASS) conventions, declaring their commitment to work hard to reverse and even halt the HIV/AIDS epidemic (NACA, 2008). As part of this global commitment each country was tasked to ensure that a total of 3 million people in the developing world can access antiretroviral drugs (ARVs) by the

year 2005. However, in the so-called **World Health Organisation “Three by Five initiative”** only a few countries of the developing world were able to meet their targets. Botswana fulfilled its pledge and by 2005 had provided access to ARVs to more than 55 000 of its AIDS clients (Kang’ethe, 2007; UNAIDS/WHO, 2005).

Ironically, when community support programmes are developed to serve people who are terminally ill, especially in the developing world, many tend to rely on women as unpaid caregivers and who may also be poor or poorer than the people they are assisting, receiving neither stipends nor incentives, despite the overwhelmingly difficult duties of care giving. The report of the United Nation’s Secretary General’s Task Force on women, girls and HIV/AIDS in South Africa points out that there are few incentives and little recognition or compensation for caregivers who may be subjects of exploitation and severe stress (Kelesetse, 1998; JHPIEGO/Botswana Ministry of Health, 2009; UNAIDS, 2000; <http://www.unfpa.org/hiv/women/report/chapter4.html>, 2005).

According to Jackson (2002), motivation and incentives in the care field to persons such as caregivers at home are critical. This is because of inadequate health-care personnel and resources to cope with the ever burgeoning number of HIV/AIDS clients in the developing world (WHO, 2002). Jackson indicates that most HIV-positive clients in developing countries may have limited access to medical services and may rarely see a professional counsellor, except at the point of HIV testing, and will therefore have to be taken care of at home by caregivers and families. It is common for most of these clients to be released from the hospitals even though they are not well because of an inadequate number of health service providers. Jackson advises that although the quality of care is likely to improve with training in counselling and nursing, the caregivers need support, incentives and motivation to know that they are doing the right thing. They also need to be assisted to take some time for a break in order to avoid stress and burnout (Nurses Association of Botswana, 2004; Strathdee, Flannery & Graydon, 1994). Most caregivers in most developing countries are women who have other tasks to cope with besides care giving. These tasks include household chores, subsistence farming or other casual employment and looking after children, elderly people and other dependants. It is also common for such caregivers taking care of infected husbands or babies to contract the disease themselves, causing their health to deteriorate while they are expected to care for everyone else (Jackson, 2002; Kang’ethe, 2006b, 2008). This article will discuss the importance of providing incentives to raising the morale and level of motivation and therefore the productivity of care programmes in Botswana.

STUDY SETTINGS AND METHODS

RESEARCH DESIGN

The adopted a qualitative design. This design is relevant because the study sought to explore the thinking, feelings and attitudes of the caregivers about their contribution to care giving, and also to investigate other gaps in, and challenges to, care giving such as lack of incentives, low morale and poor motivation. This design is appropriate for the study as it facilitates the understanding of the process – in this context the process of care giving and its operational challenges, other than the outcomes. According to Creswell (1994), qualitative research is concerned with meaning, that is, how people make sense of their lives and their lived experiences. Participant observation was also used to capture the mood and temperament of the caregivers.

RESEARCH INSTRUMENTS

Two almost similar interview guides were used, one to steer 10 focus group discussions (FGDs) with caregiver respondents, and the second to administer one-to-one in-depth interviews with the CHBC nurses. Other than the profile section of the interview guides, which required the respondent to give her/his profile data such as age, gender and educational level, all the other questions in the interview guide were open-ended questions. They only guided the discussions. The interview guides or the research instruments had been tested and refined during the pilot study that preceded the study. Nurses formed the caregivers' supervision team.

SAMPLE SELECTION CRITERIA AND PROCEDURE

All the 140 registered primary caregivers as they appeared in the Kanye CHBC register were selected for inclusion in the study. Eighty-two (59%) registered primary caregivers turned up for 10 focus group discussions. The size of the groups ranged between 6 and 12. All the focus group discussion (FGD) sessions were allotted between 60 minutes and 90 minutes. The researcher, however, stopped the session when saturation point was reached. Each respondent was involved only once in the focus group discussion. The author chooses to have only one session in a day in order to have time after every session to make arrangements and ensure that the members for the following day's session were adequately prepared for it. The CHBC register in each clinic helped to identify the number of the primary caregivers served by each clinic and hence made the sample grouping for the FGDs easier. The community caregivers (referred to as volunteers in the Botswana context) also helped to clarify the number of caregivers they were supervising and supporting in their care-giving roles. This eased the process of involving the caregivers in the study.

The focus group discussions facilitated the collection of qualitative data on the views, attitudes and thinking of the caregivers on the contributions of caregivers, and the challenges and gaps inherent in the programme, such as lack of incentives, low morale and poor motivation. Also, all the five CHBC nurses (including their coordinator) were selected to participate in the study because of their mandate of supervising the CHBC programme and the caregivers. The primary caregiver, therefore, formed the unit of analysis (Merriam, 1998). The caregivers' selection criterion and grouping disregarded age and gender, and was based on the caregivers' clinic/health post from where the caregivers were served. Depending on the number of the caregivers, some clinics involved more than one focus group discussion. FGD discussions took place at the Miracle Family Christian Centre (MFCC) church, while the CHBC nurses were each interviewed at their place of work. Notes, probing, participatory discussions, questioning and audio-taping information from the respondents formed the strategies for collecting the data.

ETHICAL AND LEGAL REQUIREMENTS

To ensure that the study complied with legal and ethical requirements, all the appropriate legal and ethical issues were addressed. Extensive and adequate debriefings, consultations before the study commenced held with the caregivers to whom all the study goals, objectives and the study process were explained. Those who agreed to participate signed consent forms. The researcher promised to adhere and maintain confidentiality and the anonymity of the respondents' data, and treat the respondents in a dignified manner in accordance with their human rights. Respondents were informed of their liberty to withdraw anytime they felt uncomfortable with the study proceedings (Neuman, 2003).

The researcher complied with all the research permit application procedures of the Human Research and Development Committee Board (HRDC) of the Ministry of Health, and was

therefore issued with a research permit for the study. The researcher then wrote a letter to the Southern District Council asking for authority to enter into the field to collect data. The letter was attended to by the Southern District Council (SDC) matron, who wrote to all the clinic heads asking them to assist the researcher in his data collection.

DATA ANALYSIS, INTERPRETATION AND BIAS REDUCTION

For data analysis both sets of information – from the focus group discussions with the primary care givers and the one-to-one interviews with the nurses – were taped and then transcribed. The huge piles of crude data were sorted, rearranged and reduced to manageable categories and themes using a coding process. This formed the basis of analysis. Quotes, words, analogies, proverbs and jotted notes were used to inform data collection, while tables and graphs were used to present the data and therefore the findings. The results from the pilot study involving five caregivers and one nurse that preceded the study had served to remove ambiguities in the instruments and had helped to focus the study more clearly. This contributed to a reduction of study bias and an improvement of data reliability and validity. There was back translation of the instruments, that is, translation from English to Setswana, and then from Setswana to English, by two independent translators, the two parties coming together to deal with the differences and any discrepancies. This also helped reduce data and result bias. Moreover, to further strengthen data reliability and validity, the two interview guides or the instruments used differed only slightly, and the two sets of responses confirmed, contrasted, corroborated and cross-checked each other.

RESEARCH DOMAIN

The data for this article were obtained from empirical research done in December 2005 and January 2006 at Kanye village. The village had a population of 40 628 persons, according to the 2001 Botswana National Census (CSO, 2001); it is well endowed with adequate health facilities in that it has a big Seventh Day Adventist (SDA) referral hospital, five clinics and two health posts. In the Botswana context the clinic is well equipped, both in terms of extent of human resource and facilities, and serves a bigger population than a health post. The research domain was chosen as the area was experiencing a progressively high death toll among the CHBC clients (DMSAC Report, 2005).

FINDINGS

PROFILE OF THE VOLUNTEER CAREGIVERS

Age, gender and educational dimension of the caregivers

While the youngest caregiver was 18 years, the oldest was 85 years, with 46 (56%) being 50 years and above; 28 (34%) were 60 years and above. The study revealed that most caregivers were women and they were apparently poor and physically not strong enough to stand the care-giving demands, especially those above 60 years. That led to psychological disillusionment and demotivation in their care-giving role. The study also found that stigma and lack of incentives were adversely affecting caregivers' morale and motivation. Caregivers therefore suggested that the care programme should consider incentive to bolster their motivation to deal with the challenges inherent in care giving.

Study findings also confirmed that 72 (88%) of the caregivers were poor and without any income to support themselves. Their poverty was demonstrated by some caregivers breaking into tears as they explained the economic and social environments in which they performed

care. Caregivers complained that they were psychologically drained by care giving and that they needed to be assisted, especially by younger people and men. They further indicated that if they were to be given some incentives, this would most likely increase their caring strength and motivation.

Regarding literacy, 74% of the caregivers had either never been to school or had only primary-level education, with only 5% of the caregivers having tertiary education. Illiteracy was found to contribute to low care productivity, low motivation and poverty. This was psychologically disabling as most of the lowly educated were also elderly and had problems accessing education on care giving, or following the medical and hygiene protocol and coping with disease progression of their clients.

Regarding gender, findings indicated that the programme faced a serious gender-skewed dimension, with 80 caregivers (98%) being women and 2 (2%) being men. Since women have other domestic chores, care giving presents a burden. It also constitutes societal exploitation that contributes to their poverty (Kang'ethe, 2009; Kelesetse, 1998).

FOOD INCENTIVE COULD MOTIVATE CAREGIVERS

About three quarters of the Kanye study respondents reported the problem of getting sufficient food as the biggest challenge besetting their care giving. They indicated that not everybody was getting the food basket, and even for those who did, it was not adequate, and sometimes some food items were over-represented while others were under-represented. They also indicated that the supplier shop sometimes gave them stale and expired food items. In all, the state of the food was disillusioning and very demotivating in the care-giving process. The following comments regarding food challenge were echoed by the majority of caregivers:

It is not all the clients who get food basket. Some of us have been waiting for the assessments results of the social workers for a long time in vain.

The food basket is standardised for all the clients, yet ailments are different.

Some food items are not there in the supplier shop. Our clients and ourselves are suffering. We need help.

Generally, the caregivers indicated that, given this challenge regarding food, care giving presented a daunting challenge and was an uphill task, making the care-giving environment very demotivating.

ADEQUATE CARE PACKAGE AS AN INCENTIVE COULD RAISE THE MORALE OF THE CAREGIVERS

Close to half of the caregivers in the Kanye study lamented that they were stressed and demoralised because of the inadequacy, unavailability and unreliability of the care package facilities in the clinics. Caregivers indicated that the programme's service provision of the care package has been deteriorating over time because of poor coordination and administration of the CHBC programme. They said that the lack of care package facilities was one of the biggest stumbling blocks to provision of quality care in the programme.

The caregivers also indicated and recommended that the care package that the government had recommended at the time of instituting the programme in 1996 be put in place to help the programme to function effectively. That, they indicated, would be a good incentive to sound care giving. According to the caregivers, some of the most important components of the care package according to the government recommendation include: gloves, napkins, bedpans,

mackintosh and draw sheets, disposable pads, incontinence sheets, disinfectants, dressing pack and supplementary feed (food basket) (NACEP 30, 1996). Provision of these facilities, the caregivers indicated, could motivate them to carry out care giving adequately.

CAREGIVERS' RECOGNITION AND INVOLVEMENT IN MAKING PROGRAMME DECISIONS COULD BE AN INCENTIVE TO RAISE THEIR MORALE

Empirical data findings in the Kanye study confirmed that there was general consensus among the respondents that caregivers are excluded from any decision making involving the running of the programme, with decisions being taken at management level without consulting the primary caregivers, yet they are the backbone of the programme. This they considered to be a lack of recognition for their efforts. Respondents expressed concern that they are not consulted or involved in the care plan and organising the care package.

We do not know anything regarding the administration of our work. We are not considered any important or consulted in anything.

CHBC authorities only communicate and consult the community caregivers [volunteers in the Botswana context]. We are in the periphery. The process is very demotivating.

This indicated a very demoralising state of affairs, demotivating the caregivers.

TRAINING AS AN INCENTIVE COULD RAISE CARE-GIVING MOTIVATION AND MORALE

The majority of the Kanye respondents complained that their programme did not have a training schedule, so they had not been trained to handle the challenges of care giving. The majority of the caregivers also reported that they were not sure of their knowledge skills in care giving and stated that they used their natural instincts and wisdom from God to perform care-giving tasks. They indicated that if they had training on care giving, they would have ample knowledge and would therefore perform their tasks with greater motivation. The following sentiments were echoed by many respondents in the focus group discussion room:

We have not had any care giving training. We use our natural God-given instincts to do care giving.

Sometimes we get confused. We do not know the results of our care giving.

We lack adequate knowledge skills on care and have not been exposed to any kind of training.

This is an indicator of the anxiety among caregivers about care giving. It is also an indicator of the inadequate motivation in their care giving. Caregivers therefore identified training as an incentive that can raise their morale and motivation in care giving.

INCOME-GENERATING PROJECTS COULD BE AN INCENTIVE TO RAISE CARE-GIVING MORALE

The empirical respondent profile data confirmed that 72 (88%) of the caregivers did not have any source of income. The majority of the caregivers confirmed they were poor, and for those whose clients received the food basket, this was the only source of nutrition. For those who were not receiving the food basket, the problem of providing food to their client was enormous. Caregivers indicated that they were struggling to provide for their clients and themselves. They

indicated that if the government or the care authorities wanted to make care giving a fruitful exercise, they should come out with poverty-reduction strategies by helping the caregivers financially to start some income-generating projects. This, they said, could act as an incentive to motivate them and possibly contribute towards raising their income and morale in their care giving.

INCENTIVES AS SOURCE OF STRENGTH AND MOTIVATION TO CARE GIVING

Other than the motivation emanating from blood relationships, which help to explain the bond between caregivers and their clients, and which is a source of strength in care giving (Bowlby, 1977), the findings indicate that the majority of the Kanye caregivers are not exposed to any other incentives to motivate them in their care-giving work. They indicated that the care programme was demoralising, lacking in incentives, recognition, rewards or any strategy to motivate the caregivers. That contributed immensely to making just coping a daunting task. Caregivers also complained that while the council recruited volunteers (the community caregivers), who were given a transport allowance to facilitate home visits, they (the primary caregivers) were not considered for any incentive and yet they were the ones who were performing most of the caring duties. They complained that lack of incentives was the reason why the programme was not attracting younger people and men generally. They made the following comments:

Incentives are not there to encourage us.

If you want men and young women to participate in care giving, give them incentives.

It was therefore apparent that care-giving productivity was seriously compromised by low morale and lack of motivation resulting from a lack of incentives.

DISCUSSIONS OF THE FINDINGS

The Kanye study findings indicate that the programme is seriously gender-skewed, with elderly women dominating the scene (Kang'ethe, 2009). The health and capacity of most of the elderly caregivers is worrying as care giving is socially, physically and psychologically stressful, and it is also emotionally draining, which is sometimes characterised as burn-out (Dant & Gully, 1994; Nurses Association of Botswana (NAB), 2004; Osei-Hwedie, 1994). This indicates that the care-giving structures in the Kanye programme are not adequately placed to deliver good-quality care (McDonnel, Brennam, Burnham & Tarantola, 1994).

Regarding aging, in their study on care giving in Kweneng, Jacques and Stegling (2001) came across three caregivers who could not discharge their care-giving roles because of old age. The researcher also found evidence during his 2006 Kanye study that two of the CHBC nurses were senile and apparently suffering from dementia. Aging in many care settings has been found to be associated with caregivers' constant illnesses, burdens, emotional strain and diminishing capacities (Hall, MacLennan & Lye, 1978). The role of incentives in addressing the state of desperation in the care process is crucial.

On the findings of the low educational status of many caregivers in the Kanye programme, other studies by Phorano, Ngwenya and Nthomang (2005) on caregivers in Maun and Kweneng found 33% of their caregiver respondents had only lower primary education. Because of the complexities and dynamism of HIV/AIDS, inadequate educational exposure presents huge coping challenges. This contributes immensely to care-giving ineffectiveness and lowered

motivation. It is recommended that care programmes, managed in liaison with the government, consider instituting a constant and on-the-job training programme for the caregivers. This is likely to raise morale and motivation and therefore lead to increased caregiver productivity.

In the Kanye study poverty was found to be a challenge and a stumbling block to effective care giving. Page and Davies (1999), and the Food and Nutritional Technology Assistance Project (FANTA) (2000), suggest that HIV/AIDS aggravates the problem of poverty amongst the households. This is attributed to the fact that morbidity and mortality reduce the time and human capital available to the households (Ainsworth, 1993). According to UNAIDS (2000), AIDS is a poverty-friendly disease. This is because even those who are financially well endowed are rapidly reduced to poverty when the breadwinners are struck down by the disease, or working persons in the family are forced to give up employment, or to work in the family fields in order to offer care to the client. A director of a home-based care programme in South Africa quoted in UNAIDS (2000) wonders what good it does to bring pain killers to the household only to find that the caregiver in the household doesn't have the strength to roll the patient over because she is starving herself. It is suggested that care authorities working in liaison with the government come up with poverty-reduction strategies so that caregivers can be economically active as they perform their care giving tasks. This can give the caregivers greater morale and the motivation to care.

Subjective information provided in Kanye indicated that some clients were even dying while waiting for the assessment results of the social workers and therefore the food baskets. The 2004 research study in Kanye on care giving (Kang'ethe, 2004) revealed that the content of the food basket was not adequate. This researcher learnt from the administrators of the food basket that it was standardised for all the clients for logistical and administrative convenience. This was to make provision easier and yet different clients had different ailments. Sometimes some food items were over-represented, while at times some were under-represented. This was the suppliers' fault. As the food basket was meant to solve the nutritional challenge of the client or the sick person, it would be logical if the administration would consider having the caregiver's package, or the food basket, adjusted to include the caregiver's portion. This is because the researcher learnt that one of the reasons why the food basket was not adequate was that the caregivers and inevitably other family members were also fed from it, making it last for barely two weeks. Including the caregiver's portion in the food basket would be an incentive and will no doubt encourage and motivate the caregiver to provide a better service. According to UNAIDS (2000), it is hard to look after one's family when one is not earning a cent for the caring job. Many caregivers reported going to visit hungry people while they are hungry themselves. It is common for caregivers to spend all day in the field visiting clients without anything to eat or drink. There is usually no budget for refreshments in most care programmes. It is therefore essential that care managers and the government consider instituting incentives to motivate caregivers in their practice.

The issue of the availability, adequacy and quality of food in this era of ARVs needs careful handling. The ARV client, for example, needs adequate, nutritious food and a well-balanced diet, which the food basket may not adequately provide. The economic circumstances of each of the clients need to be adequately explored for possible individualised interventions. Reinforcing this point and concern that adequate and nutritional food need be available for HIV/AIDS clients, the Executive Secretary of South African Development Cooperation (SADC), Dr Salomao, said in the *Agrinews Magazine* of October 2006 that the ARV roll out would not achieve the desired results in the SADC region if food security is not adequately

addressed. He commented that “There is no point in giving people ARVs on an empty stomach” (Agrinews, 2006:10). According to the community home-based care programme objectives at the time of its institutionalisation, since the food basket was meant to cushion the nutritional and food challenges of the clients, care managers and the government need to go back to the drawing board and address the logistical and administrative flaws making provision of the food basket problematic. The adequacy and availability of the food basket is an incentive and has a motivational value for care giving (Makubalo & Msiska, 1995). In Munodawafa’s (1998) study on care giving in Botswana, food shortages, especially for the clients, were a big challenge. He recommended that strategies and mechanism to provide supplementary food to the CHBC clients be worked out without delay. This would ensure that caregivers’ stress about the availability of food is reduced, and this would in itself be a source of greater motivation in care giving (Huzynski, 1987).

On the challenge of the unavailability of, or inadequate, care package facilities, a spot visit made by the researcher to all the clinics in the area revealed that close to fifty percent of the care package facilities as recommended by the government CHBC 1996 policy were not there (NACP 30, 31, 1996). Lack of adequate care package facilities has serious health implication in that caregivers would be forced to buy those items, recycle what they have, or do without. This would possibly mean some of the desperate caregivers would have to wash their clients without any protective clothing. This exposes them to the challenge of infection (Kang’ethe, 2008). It is recommended that the government, working in collaboration with the CHBC authorities, institute and intensify monitoring and evaluation of the programme and ensure that the programme has adequate care package to ensure quality care giving. NGOs and other players in the field of HIV/AIDS need to assist and complement government efforts in the provision of care packages (Kang’ethe, 2006a, 2010).

The Kanye caregivers indicated they were not considered or consulted by care authorities on decisions pertaining to the running of the programme or on the care plan. According to Uys and Cameron (2003), it should be the responsibility of CHBC health workers to go to the homes to involve and help the caregivers, and in the presence of the client where possible, show or help develop a care plan and care package. Uys and Cameron (2003) further advise that involving the caregivers in developing and making the care plan is very important. It also heralds a strengthened ownership of care giving. This has the advantage of strengthening cooperation between the caregiver and the client, and hence reduces any chances of conflict in the care process (Dant & Gully, 1994). Care giving should be a participatory process, with the caregiver and the client being given due consideration as they are important stakeholders determining the success of the programme. It is recommended that policy changes to accommodate caregivers in decision-making process need be worked out, otherwise motivation in care giving will always be low, which will continue to compromise the productivity of care giving. Involving caregivers and recognising them could go along way in bolstering their sense of ownership and motivation in their care-giving tasks (Kang’ethe, 2006a).

The Kanye caregivers indicated feeling seriously challenged by lack of training, which greatly affected their care-giving effectiveness. According to Abbat and Meija (1998) and Nowlen (1998), training, and especially on-the-job training, will increase the knowledge of the workers such as caregivers, resulting in greater efficiency as well as heightened morale and productivity. A guide by the Botswana Ministry of Health, produced in collaboration with the Harvard School of Public Health Initiative (2007), recommends that training in especially hygiene, palliative care, oral care, self care, syndromic management of opportunistic infections,

sexually transmitted infections, counselling, testing and community care are of significant importance to caregivers. Munodawafa's (1998) study on care giving in Botswana recommended training and continuous education for health professionals, clients and caregivers. The trainers should, however, allow for an open dialogue in order for participants' real and perceived needs to be addressed. He also recommended that programme consider peer training by bringing clients and caregivers together to discuss their experiences in home-based care, or getting family welfare educators (FWEs) or nurses to visit other HBC programmes as a way of sharing experience.

Providing quality courses and other training opportunities is a tried and tested way in many settings of increasing the effectiveness and productivity of management, workers and volunteers. Moreover, findings from employment organisations and their alumni trained by UNAIDS Regional AIDS Training Network (RATN), which covers East and Southern Africa, indicate a very high level of satisfaction leading to improved operational skills in the workplace and, for some, an increased level of confidence and interpersonal skills. However, the project recommends conducting and using training needs assessment data as a guide, ensuring that training interventions are relevant to actual needs (UNAIDS, 2001). It is recommended that care authorities working in liaison with government adjust or reinforce policy to provide for continued on-the-job training to the caregivers.

Regarding income-generating projects as incentives to bolster care giving, Botswana needs to learn from other countries that have taken the issue of caregivers seriously. Catholic AIDS Action in Namibia, responding to complaints by caregivers that many families they serve do not have food, making the caregivers feel obliged to share their own, has endeavoured to address lack of income among caregivers and clients by helping caregivers start income-generating activities through beadwork, sewing and making toys for sale (UNAIDS, 2000). The Hope Worldwide programme in South Africa also helps its caregivers organise income-generating projects such as tending vegetable gardens around the clinics. The organisation, however, seeks expert advice to guide these projects (UNAIDS, 1999, 2000). Molweni AIDS Centre and Woza Moya caregivers in South Africa have been trained in beadwork, fabric painting, sewing and vegetable gardening. Sales of their products results in substantial payouts to members, while other members engage in selling second-hand clothes provided by the centre. They do these activities along with their care giving duties in the community (Byamugisha, Steinitz, Williams, & Zondi, 2002).

World Vision in South Africa offers income-generating activities to caregivers to help them cope financially. The income-generating projects usually involve groups of people working together in a particular project. This affords people the opportunity to talk and give each other mutual support that can have a positive impact on their emotions. Agricultural experts to help caregivers augment their skills in food production have been brought in by the organisation. Experts also come up with 'model farmers', whereby a few people (especially those trained and using their own farms as demonstration plots) act as a resource for training others in the community, especially families impoverished through AIDS who want to learn to increase the yield from their land (UNAIDS, 2000).

In Botswana the issue of supporting the caregivers is not appropriately addressed and is moving at a snail's pace. While the government has instituted programmes to assist HIV/AIDS clients, there are no coherent programmes to assist the caregivers in the form of financial or material resources. It is therefore recommended that Botswana government and care managers, NGOs and any other organisation in the care field borrow best-practice ideas on income-generating

activities from the neighbouring countries. This is to expedite starting their own income-generating projects.

The Kanye caregivers decried the lack of incentives generally. Incentives, according to the respondents, include giving stipends, bonuses, encouraging words, food packages, toiletries, visits and supervision, relieving somebody before he/she becomes overwhelmed by working in turns and monetary payments. The literature indicates that the issue of especially financial incentives has been taken seriously by other countries. While the Kanye CHBC programme lacked such incentives, Chirumhanzi CHBC caregivers in Zimbabwe receive an incentive in the form of a year's pocket money in a lump sum, while the Aids Service Organisation (TASO) in Uganda pays its volunteers more than other government workers of their calibre. TASO also intends to introduce a policy of assisting at least two children of a sick caregiver by paying school fees as an incentive and motivation to quality care giving (UNAIDS, 1999). In Namibian care programmes generally caregivers are given bonuses and a little money to support their living, while the Hillcrest AIDS centre caregivers in South Africa receive no money, but are given as incentives a monthly supply of basic foods such as mealie meal, beans, rice, sugar and tea (UNAIDS, 1999).

According to Huczynski (1987), the purpose of an incentive or reward is to facilitate positive changes or behaviour that will result in increased productivity. While an appropriate reward system contributes to organisational health and productivity, an inappropriate reward system sabotages and stifles morale, with the result being lowered productivity. Lawler (1994) considers the level of pay as a barometer to measure work morale, and therefore the expected productivity, while Kohn (1993) supports the reward system, not only in the form of payment, but also praise or prizes. It is recommended that care authorities create an environment resulting in recognition and appreciation of caregivers' work. That would be an important factor that can raise the caregivers' morale. Botswana care managers need to look at the way other African countries are treating their caregivers as far as giving them incentives is concerned in order to raise the caregivers' productivity and morale. The government of Botswana, for instance, could consider what the Mozambique government has done: it has drawn up an attractive policy to remunerate the caregivers with a package of 60% of the government minimum wage, which is about \$55 per month. This is adequate goodwill as Botswana is far better endowed with financial resources compared to Mozambique.

CONCLUSION

Care giving in many care settings, especially in developing world, has been found to be overwhelming, stressful and unappealing to caregivers. This is because of the uncongenial atmosphere under which it operates, namely an environment lacking in many resources to attract caregivers and others to care giving. The role and availability of incentives to motivate and raise the caregivers' morale has been found critical in determining the quality and productivity of care giving. Governments and care managers have been asked to consider adjusting policies to put in place incentives for the caregivers. They can look at countries such as Mozambique, which has already instituted incentives to caregivers as a matter of policy.

REFERENCES

- ABBAT, F.R. & MEIJA, A. 1988. **Continuing the education of health workers**. Geneva: World Health Organization.
- AGRINEWS. 2006. No point giving people ARVs on empty stomachs. **AgriNews**, 37(10). Farmers' Monthly Magazine. Ministry of Agriculture.
- BOWLBY, J. 1977. The making and breaking of affectional bonds. **British Journal of Psychiatry**, 130:201-210; 421-431.
- BYAMUGISHA, G., STEINITZ, L.Y., WILLIAMS, G. & ZONDI, P. 2002. **Journeys of faith. Church based responses to HIV and AIDS on three Southern African countries**. Oxford, UK: G & A Williams.
- CRESWELL, J.W. 1994. **Research design. Qualitative & quantitative**. London: Sage Publications.
- CSO. 2001. **Central Statistics Office**. Gaborone: Government Printers.
- DANT, T. & GULLY, V. 1994. **Coordinating care at home**. London: Collins.
- DMSAC REPORT. 2005. **District multi-sectoral AIDS committee report** presented at Rural Administration Centre (RAC) in Kanye, Southern District of Botswana in November 2005.
- FOOD AND NUTRITION TECHNOLOGY ASSISTANCE (FANTA). 2000. **Potential uses of food aid to support HIV/AIDS mitigation activities in Sub Saharan Africa**. [Online] Available: <http://www.Fantaproject.org>. [Accessed: 13/09/2001].
- HALL, M.R., MacLENNAN, W.J. & LYE, M.D. 1978. **Medical care of the elderly**. London: Alden Press.
- <http://www.unfpa.org/hiv/women/report/chapter4.html>. 2005. **Women and HIV/AIDS. Confronting the crises**. A joint report by UNAIDS/UNFPA/UNIFEM. Retrieved on 10th July 2005.
- <http://www.irinews.org/aidsreport.asp>? Mozambique. **Financial incentive to attract home based HIV/AIDS caregivers**. Retrieved on 10/1/2005. 2005.
- HUCZYNSKI, A. 1987. **Encyclopaedia of organizational change methods**. Brookfield, VT, US: Gower Publishing Co Ltd.
- JACKSON, H. 2002. **AIDS AFRICA. Continent in crises**. Safaids, Avondale, Harare, Zimbabwe.
- JACQUES, G. & STEGLING, C. 2001. **Panacea or Perfidy?** Paper presented at the 3rd International Conference on Social Work in Health and Mental Health, July 1-5, Tampere, Finland.
- JHPIEGO/BOTSWANA MINISTRY OF HEALTH. 2009. **Situational analysis of the care and treatment of PLWHA in Botswana**. Draft Report.
- KANG'ETHE, S.M. 2004. **Issues and challenges of community home based care in Africa. Case of Botswana**. University of Botswana: Department of Social Work, Faculty of Social Sciences. (Research essay for MA degree in Social Work)
- KANG'ETHE, S.M. 2006a. **Contribution of caregivers in community home based care programmes: the case of Kanye, Botswana**. University of North West, Mafikeng Campus: Department of Social Work, Faculty of Social Sciences. (Unpublished PhD Dissertation)

- KANG'ETHE, S.M. 2006b Clinical waste is hazardous. *Botswana Mid-Week Sun Newspaper*. 31st May: 9.
- KANG'ETHE, S.M. 2007. Botswana hits world health organization targets. *Botswana Guardian Newspaper*. 9th March: 7.
- KANG'ETHE, S.M. 2008. Clinical waste management in the context of the Kanye community home-based care programme. **African Journal of AIDS Research**, 7(2):187-194.
- KANG'ETHE, S.M. 2009. Inadequate male involvement in health Issues: the cause of gender skewed HIV and AIDs situations in Botswana. **In: MAUNDENI, T., OSEI-HWEDIE, B.Z., MUKAAMAMBO, E. & NTSEANE, P.G. (eds) Male involvement in sexual and reproductive health. Prevention of violence and HIV/AIDS in Botswana.** Cape Town: Made Plain Communications.
- KANG'ETHE, S.M. 2010. Evaluation of the local Non Governmental Organizations (NGOs) support to care giving in Kanye care programme, Botswana. **Professional journal for the social worker/Maatskaplike Werk** 2010(46)(2):209-223.
- KELESETSE, N.M. 1998. **AIDS, home based care and the status of women in Botswana.** A case study of Mogoditshane. Gaborone: University of Botswana. (BA Thesis)
- KHAN, B. & STEGLING, C. 2000. **An evaluation of the Kweneng district AIDS Home Based Care Programme.** Gaborone: SNV, Netherlands Development Organisation.
- KOHN, A. 1993. **Punished by rewards.** Boston. Houghton Mifflin.
- LAWLER, E.E. 1994. **Motivation in work organization:** San Francisco: Jossey-Bass.
- MAKUBALO, E.L. & MSISKA, R. 1995. **A home based care programme for Botswana.** Implementation & M.O.H/World Bank project.
- McDONNELL, S., BRENNAN, M., BURNHAM, G. & TARANTOLA, D. 1994. Assessing and planning home based care for persons with AIDS. **Health Policy and Planning**, 9(4):429-437.
- MERRIAM, S.B. 1988. **Case study research in education: a qualitative approach.** San Francisco: Jossey-Bass.
- MINISTRY OF HEALTH (MOH)/ BOTSWANA HARVARD SCHOOL OF PUBLIC HEALTH AIDS INITIATIVE.2007. **Chronic HIV Care with ARV Therapy.** Botswana Integrated Management for HIV/AIDS and other illness. Gaborone,
- MOJAPELO, D., DITIRAFALO, T., TAU, M. & DOEHLIE, E. 2001. **Client satisfaction and providers perspectives of Home Based care in Kweneng District,** Botswana, Unpublished Report, Gaborone.
- MUNODAWAFA, D. 1998. **Evaluation of the CHBC Pilot Project (Molepolole & Tutume Sub District.** NACP 41, Gaborone.
- NACA. 2005. NATIONAL AIDS COORDINATING AGENCY (NACA). 2005. **Botswana Second Generations HIV/AIDS Surveillance.** Technical Report.
- NACA. 2008. **Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS.** ACHAP/UNAIDS.
- NATIONAL AIDS CONTROL PROGRAMME (NACP) 30. 1996. **Community home based care for people living with AIDS in Botswana.** AIDS STD Unit, Gaborone.

- NATIONAL AIDS CONTROL PROGRAMME (NACP) 31. 1996. **Baseline study for the community home based care programmes for terminally ill HIV/AIDS patients in Botswana.** Gaborone, Botswana.
- NEUMAN, L.W. 2003. **Social research methods-quantitative and qualitative approaches.** Boston, MA: Allyn & Bacon.
- NOWLEN, P.M. 1988. **A new approach to continuing education for business and the professions.** New York: American Council on Education & MacMillan Publishing Company.
- NURSES ASSOCIATION OF BOTSWANA (NAB). 2004. **Caring for the caregivers.** Gaborone: Kgotla Designs Pty Ltd.
- OSEI-HWEDIE, K. 1994. The individual, family and community. Psychosocial issues. **Journal of Social Development in Africa**, 9(2):32-43.
- PAGE, S.L. & DAVIES, M. 1999. Farmer field schools as support groups for AIDS widows and other marginalized smallholder farmers in Zimbabwe. In: MUTANGANDURA, G., JACKSON, H. & MUKURAZITA, D. (eds) **AIDS and African smallholder agriculture.** Harare: SAFAIDS.
- PHORANO, O.M., NTHOMANG, K. & NGWENYA, B.N. 2005. HIV/AIDS home based care and waste disposal in Botswana (ed) **Botswana Notes and Records. Botswana Society**, 37:161-178. Gaborone, Botswana.
- STRATHDEE, S., FLANNERY, J. & GRAYDON, D. 1994. Stressors in the AIDS Service Organization. **AIDS Patient Care.** April, 82-89.
- UNAIDS. 1999. **Comfort and hope. Six case studies on mobilizing family a community care for and by people with HIV/AIDS,** June. Geneva, Switzerland.
- UNAIDS. 2000. **Caring for carers. Managing stress in those who care for people with HIV and AIDS.** UNAIDS case study. May. Geneva, Switzerland.
- UNAIDS. 2001. **Promoting excellence in training. The Regional Training Network (RATN).** UNAIDS case study. UNAIDS Best Practice Collection. June.
- UNAIDS/WHO. 2005. **AIDS epidemic update.** December 2005. Geneva, Switzerland.
- UYS, L. & CAMERON, S. 2003. **Home based HIV/AIDS care.** Cape Town: Oxford University Press.

Dr Simon M Kang'ethe, Department of Social Development, University of Fort Hare, South Africa.