The work-related experiences of psychologists in public health facilities in Botswana.

Warona Solomon

12281485

Supervisor: Dr Assie Gildenhuys

Dissertation submitted in partial fulfilment of the requirements for the degree of Master of Arts in Counselling Psychology in the Faculty of Humanities at the University of Pretoria, South Africa, in November 2019.

Declaration

I, Warona Tshepiso Solomon, declare that the dissertation '*The work-related experiences of psychologists in public health facilities in Botswana'* is my own academic work and has no previous submissions for a degree by me at any other institution. All citations have been acknowledged and are deemed to be complete and reliable.

Warona Tshepiso Solomon

Signature: _____________________

Date: _________________________

Acknowledgements

- First and foremost I would like to acknowledge and thank Jesus Christ my Lord and Saviour for getting me through this dissertation.
- A tribute to the woman who gave birth to me, my mother, Letsema Patricia Solomon. I know she would have been proud of me. I know her soul is resting in peace with Jesus.
- To my baby sister Masa Boleng Solomon, you are the reason I did not want to quit. I love you more than words can say.
- My aunt and mother Semakaleng Bushy Solomon. Thank you for being my rock! Your love for me is beyond comprehension.
- I would like to thank my supervisor Dr Assie A. Gildenhuys for his patience, his valuable input and attention to detail. This dissertation would not have been possible without your guidance and thoughtful approach. You handled this paper with care and for that I am thankful. Your commitment and dedication are highly appreciated.
- To my beautiful family, thank you for your unwavering support. I could not have done this without you. Thank you for believing in me. Your words of encouragement were the fuel to my fire. I cannot thank you enough for your unconditional love. Cousins you are all amazing. Aunties and uncles thank you for standing by me.
- I would like to thank my friends, you all would not allow me to give up. You were my source of inspiration. You were never too tired to lift me up. I appreciate you.

- To my one and only, my spouse Leroy Nyoni. I have no words to describe what or who you have been through this entire dissertation. Thank you for your support. May God continue to bless you, my angel.
- To my editor Dr Noleen D. Loubser. You couldn't have come at a better time. Your assistance is highly appreciated.
- To my respondents, thank you for taking part in this study. Thank you for taking the time out of your busy schedules to assist me. I appreciate the work that you do for our country. Thank you for setting the foundation for psychology, your contribution will never be forgotten.

Abstract

The current study explored the work-related experiences of psychologists in public health facilities in Botswana. This topic has received minimal research attention, yet the World Health Organization has recognised the importance of treating mental health conditions. There is also recognition that there is a shortage of mental health practitioners, especially psychologists, in low to middle income countries such as Botswana. For this reason, the World Health Organisation has developed an initiative amongst its member states to increase access to mental health services by integrating them into the general health system. This is where psychologists in public health facilities are employed.

In order to investigate how psychologists in public health facilities experience this integration, an explorative design was followed which adopted a qualitative methodology for data collection and analysis. Three semi-structured interviews were conducted with clinical psychologists who were recruited through purposive sampling. The data were analysed through thematic analysis. Generally, the participants experienced their work in the public health facilities as a professionally enhancing experience in spite of the various challenges encountered. They described a wide range of supportive and therapeutic functions that served the institutions and society in general. It is hoped that the results of this study can inform policies on mental health and add some valuable insight for further investigation of this topic.

KEYWORDS: Clinical psychologists, Public health facilities, Botswana, Mental health policy

Abbreviations

DPSM	Directorate of Public Service Management
EMERALD	Emerging mental health systems in low and middle-income countries
HSPAF	Health System Performance Assessment Frame
LMICs	Low-income and middle-income countries
MOH	Ministry of Heath
WHO	World Health Organisation
WHO-AIMS	World Health Organization Assessment Instrument for Mental Health Systems

Contents

Declaration ii
Acknowledgements iii
Abstract v
Abbreviations vi
Contents vii
Chapter One: Introduction 1
1.1. Introduction 1
1.2. Background 1
1.3. Research Problem 2
1.4. Significance of the study 4
1.5. The aim of the study 4
1.6. Literature Review 4
1.7. Methodology 5
1.8. Research Results 6
1.9. Discussion and Conclusion 6
Chapter Two: Literature Review 8
2.1. Introduction 8
2.2. Understanding the role of Mental Health Policy 8
2.3. Botswana's Mental Health Policy 13
2.4. Botswana's Health System 17
2.5. Mental Health in Africa 20
2.6. The role of Psychologists in Public Health Facilities 25
2.7. Psychology as Practiced in Botswana 27
2.8. Experiences of Psychologists in Public Health Facilities 28
2.9. Conclusion 32
Chapter Three: Methodology 34
3.1. Introduction 34
3.2. Theoretical Framework 34
3.3. Epistemology and Ontology 35
3.4. Methodology 37
3.4.1. Qualitative Research 37
3.4.2. Research Site 37
3.4.3. Research Environment 38
3.4.4. Research Design 38

3.4.5. Limitations 40
3.5. Method 40
3.5.1. Sampling 40
3.5.2. Health Facilities Used 42
3.5.3. Data Collection 42
3.5.4. Data analysis 43
3.5.5. Reflexivity 45
3.6. Ethical Considerations 47
3.7. Conclusion 48
Chapter Four: Results 49
4.1. Introduction 49
4.2. Data Analysis 50
4.3. Results of study 52
4.3.1. Formal recruitment by the government through the Ministry of Health . 53
4.3.2. Professional role obligations 54
4.3.3. Upholding a high standard of patient care 55
4.3.4. Psychotherapy 56
4.3.5. Internal and external barriers to treatment 61
4.3.6. Resource limitations 64
4.3.7. Heavy caseload 65
4.3.8. Foreign psychologists 66
4.3.9. Institutional level support structures 66
4.3.10. Communication gap 67
4.3.11. Support functions 68
4.3.12. Employment in the public health setting as a rewarding experience . 69
4.3.13. Experience of the regulating body 70
4.3.14. Establishing a new department 71
4.3.15. The role of psychology 72
4.3.16. Creating an atmosphere for learning and mentorship 73
4.4. Conclusion 77
Chapter Five: Discussion 78
5.1. Introduction 78
5.2. Review of the study 78
5.3. Summary of results 79
5.3.1. Formal recruitment by the government through the Ministry of Health . 80

5.3.2. Professional role obligations ... 80
5.3.3. Upholding a high standard of care ... 81
5.3.4. Psychotherapy ... 82
5.3.5. Internal and external barriers to treatment ... 83
5.3.6. Resource limitations ... 84
5.3.7. Heavy caseload ... 86
5.3.8. Foreign psychologists ... 87
5.3.9. Institutional level support structures ... 87
5.3.10. Communication gap ... 87
5.3.11. Support functions ... 88
5.3.12. Employment in the public health setting as a rewarding experience ... 88
5.3.13. Experience of the regulating body ... 89
5.3.14. Establishing a new department ... 89
5.3.15. The role of psychology ... 90
5.3.16. Creating an environment for learning and mentorship ... 90
5.4. Accountability of the study ... 92
5.5. Research conclusions ... 93
5.5.1. Objective 1: To explore psychologists' experiences of their integration into public health facilities ... 94
5.5.2. Objective 2: To explore how psychologists within public health facilities experienced work-related challenges ... 95
5.5.3. Objective 3: To explore psychologists' experiences of job satisfaction and support ... 95
5.6. Research Reflections ... 95
5.7. Limitations of the study ... 96
5.8. Recommendations ... 98
5.9. A Reflection ... 99
5.10. A Personal Note ... 100
References ... 101
Appendix A: University of Pretoria Ethical Clearance ... 116
Appendix B: Ethical clearance from the Ministry of Health ... 117
Appendix C: Ethical clearance from the hospitals ... 119
Appendix D: Consent Letter to Participants ... 120
Appendix E: Interview Schedule ... 122
Appendix F: Initial Codings ... 123
Appendix G: Editing Letter ... 142

Chapter One: Introduction

1.1. Introduction

This chapter provides a description of the study. It is a brief summary of each chapter that explains the nature and purpose of the study. It provides the breadth and scope of the study by detailing some relevant knowledge on the topic. It introduces the location of the study, its justification and significance.

This specific study aims to develop an understanding of the work-related experiences of psychologists in public health facilities in Botswana. It elaborates on the situation in Botswana as it pertains to psychologists in public health facilities. This chapter sets the foundation of the study by outlining the methodology, theoretical framework, results, discussion and conclusion.

1.2. Background

The current research aims to gain an understanding of the work-related experiences of psychologists in the public health setting in Botswana. Limited research has been done on the integration of psychological services in the public health setting in Botswana (July, 2009). The integration of psychological services was aimed at increasing access to mental health services and providing a more holistic approach to medical and psychological conditions (Ministry of Health [MOH], 2003; Word Health Organisation [WHO], 2013). In addition, many countries around the world have been experiencing a gradual proliferation of mental health conditions (WHO, 2017). This increase has created a burden of untreated mental health conditions (Janse van Rensburg & Fourie, 2016). In an effort to combat this, the

World Health Organisation has organised a mental health policy campaign for its member states (WHO, 2013).

Although the implementation of a mental health policy is considered to be a worthwhile endeavour, its implementation has been challenging for many countries, especially for the low- to middle-income countries (WHO, 2013). Botswana seems to have similar challenges. These include a lack of resources and problems with funding (Nkomazana, Peersman, Willcox, Mash & Phaladze, 2014).

The Botswana government is responsible for the provision of most health care services (Olwabi, 2012). Health care services are divided into three levels of care, primary care, secondary, care and tertiary care (Seloilwe & Thupayagale-Tshweneagae, 2007). Access to health services is assured because the majority of the population is located within a 5 to 11 kilometre radius of a health facility (Olwabi, 2012). This is an indication that most of the population has access to health care services (Olwabi, 2012). Many challenges remain, even with such extended coverage. Most of the specialised services such as mental health are located in urban areas, towns and larger villages (Seloilwe & Thupayagale-Tshweneagae, 2007). For those who have access to health services, there is a shortage of mental health specialists (Seitio- Kgokgwe, Gauld, Hill and Barnett, 2014). Given these circumstances, the research question is: What are the work-related experiences of psychologists working in public health facilities in Botswana?

1.3. Research Problem

Not much research has been conducted on the experiences of psychologists since their integration into public health facilities (July, 2009). This poses a

challenge as psychological services are a valuable addition to the health setting (Wahass, 2005). The clinical application of psychology incorporates the knowledge of biological, psychological, cultural and social factors into treatment (McDaniel & DeGruy, 2014). In addition, psychologists can work with individuals, families, groups and special populations such as the elderly and children. (Wahass, 2005). This kind of skill set can greatly improve treatment outcomes for many in health settings (Wahass, 2005).

The WHO (2017) has shown that there has been a global increase in mental health conditions (Monteiro, 2015). This is why it is important to address issues concerning mental health services. Although not a very recent study, Cox (2011) found that almost a quarter of patients presenting at hospitals with a physiological condition had a psychological condition.

Psychologists in public health facilities face many challenges (Pillay, Kramers-Olen, Kritzinger & Matshazi, 2012). These challenges pertain to limited access to professional growth, lack of resources, unequal staff to patient ratio, and a lack of support (De Sousa & Dela Coleta, 2015). Limited research exists internationally on the experiences of psychologists in such circumstances (Safarjan, 2002). This could be an indication that this topic is a developing field that requires more scientific support, and an indication that this research could yield some valuable data.

The scope of this study has been limited to the work-related experiences of psychologists in public health facilities in Botswana. The study does not go beyond the work-related experiences of psychologists in this particular context. It focuses specifically on one branch of psychology; namely, clinical psychology.

1.4. Significance of the study

There has been very little research on the profession of psychology in Botswana (Pheko, Monteiro, Kote & Balogun, 2013). A study such as this could add to the knowledge of psychology as a profession in Botswana. The few studies that have been conducted are not recent. This study could provide a more recent account of the current situation with psychological services in Botswana. In addition, there is a global shortage of mental health professionals, especially psychologists, in low to middle income countries (WHO, 2013). Botswana is no exception to this global shortage. A research study such as this could possibly provide some valuable insight into how the situation can best be addressed.

1.5. The aim of the study

The aim of the study is to understand the work-related experiences of psychologists working in public health facilities in Botswana with the specific intention of meeting the following objectives:

- To explore psychologists' experiences of their integration into public health facilities;
- To explore how psychologists within public health facilities experience work-related challenges; and
- To explore psychologists' experiences of job satisfaction and support.

1.6. Literature Review

The literature review is found in the second chapter and addresses issues concerning the integration of psychologists in public health facilities and the mental

health policies surrounding psychologists' inclusion into the public health system. It explains the main aims of the policies and their proposed implementation. Most of the policies were developed as part of the WHO initiative to increase the accessibility to mental health services around the world. This chapter focuses on what has been found regarding mental health policies and their implementation in African countries similar to Botswana. The review also expands on the governing structures responsible for implementing these policies and the current situation in Botswana.

The review also touches on the experiences of psychologists in public health settings. A number of factors are involved in these experiences, such as working conditions, challenges, work roles and work environment. An overview of the current state of psychology in Botswana is also provided. This chapter highlights the gaps in the literature and provides a critical discussion of previous findings, linking them to the study.

1.7. Methodology

In Chapter Three, the methodology of the study is outlined. First, a description of the research paradigm is provided followed by the research methodology and methods. The methodology section explains how the research design informed the sampling, data collection and data analysis methods. The researcher's role is also included in this chapter. The chapter also explains how the chosen methodology fulfils the aim of the study.

The theoretical framework is also outlined in this chapter. The study used an ecological systems framework. This theory suggests that the individual is placed within five different levels of a system. The levels are connected and have a

reciprocal relationship with one another. The levels consist of the microsystem, mesosystem, exosystem, macrosystem and chronosystem, which are outlined in detail in this chapter.

The study was explorative and used a qualitative methodology, generating data through semi-structured interviews. The research participants were purposively selected, specifically selecting clinical psychologists with the experience of working in a public health facility. Thematic analysis was the chosen method of analysis. The researcher followed a reflexive process in order to maintain the accountability of the research. Ethical clearance was obtained from all relevant organisations and is included in an appendix.

1.8. Research Results

Chapter Four presents the results of the data analysis. It first provides greater detail into how the data were analysed and then presents the results. The method of analysis was a six-phase process that involved repeated reviews of the data. Through this process, data from transcripts were organised into meaningful categories. This recursive process was meant to identify codes and provisional themes that would finally generate the main themes to be reported in the results. The coding tables have been included in an appendix.

1.9. Discussion and Conclusion

Chapter Five is an integration of the study as a whole. It presents a summary of the results and makes interpretations of the findings. It compares the findings with those published in the literature. It discusses whether the research questions have been answered, how certain factors affected the results both positively and

negatively, the researcher’s reflexivity, and the theoretical explanation of the results. It ties in the recommendations from participants as well as the recommendations that emerge from the study. This also incorporates the conclusion, which discusses the limitations and integrates the whole study.

This chapter has served as an introduction to the research outlining the progression of the study. The intention and contribution of the study have been described. A review of the literature follows in the next chapter.

Chapter Two: Literature Review

2.1. Introduction

Psychology is an important profession in the public health sector. However not much is known about the experiences of psychologists in public health facilities. In addition, there is limited research about psychology or psychologists in Botswana. This literature review attempts to provide a picture of what psychologists might experience in the public health facility. As a way of understanding these experiences, a systemic approach is used. This involves looking at various aspects such mental health policies, their implementation as well as their impact on the entire mental health system. The current study is focused on Botswana and how its mental health policy and health system function. What will also be addressed is how these systemic implications affect psychologists working in public health facilities.

2.2. Understanding the role of Mental Health Policy

The mental health of a population plays an important role in its functioning and adaptation (MOH, 2003). It is thus important to ensure that the mental health needs of a society are taken care of. For several years, research has revealed the burden caused by untreated mental health disorders (WHO, 2011; WHO, 2013). For instance, the estimated global economic costs related to mental health in 2010 was US $ 2.5 trillion and was projected to increase to 6 trillion in 2030 (Bloom et. al., 2011, as cited in Janse van Rensburg & Fourie, 2016).

Statistics from the WHO (2017) predicted a global increase of common mental health disorders which is of great concern since these disorders lead to poor

outcomes for general well-being. Such statistics as well as a general understanding of mental health conditions is important for health policies, planning and evaluation (WHO, 2017). With these health trends in mind, most WHO member states have developed mental health policies to address the growing burden of mental health conditions (WHO, 2013). The WHO action plan for mental health urges its member states to develop effective policies to guide practice, to protect human rights and monitor the implementation of regulations (WHO, 2013). In the African region, older research as well as newer research has shown that approximately 50% of African member states have a mental health policy (WHO, 2005; Awenva, et, al., 2010; Bird, et al., 2011). Reuter, McGinnis & Reuter (2016) reported that 42 percent of countries in the African region have adopted mental health policies, which is less than other regions such as the Americas (56%), Europe (73%), South East Asia (70%), Eastern Mediterranean (68%), and the Western Pacific (58%). This possibly demonstrates that policy development and implementation in this region is developing slowly.

According to the WHO (2007), a mental health policy is a formal statement by a government or health ministry that provides a way forward by creating a vision, values, principles and objectives that will reach the envisioned mental health goal. Such a policy is considered effective when it incorporates a plan of action that specifies the strategies and activities for implementation (WHO, 2007). The policy is the overall vision whilst the plan is the operational and practical tool used to realise the policy (WHO, 2007). The policy contains various components such as financing, legislation, human rights, health promotion, prevention, provision of medication, advocacy, quality improvement, information systems, human resources and training, research, evaluation, and intersectoral collaboration (WHO, 2007).

The policy and plan are based on data and evidence which are derived from the country's mental health context, the population's mental health needs, and the financial and human resources (WHO, 2007). Research and international collaboration also guide policy development and planning (WHO, 2007).

Although there is a global recognition of mental health policy development and planning, the implementation is challenging for most countries (WHO, 2011). According to the WHO (2011), the shortage of human resources creates a large treatment gap between mental health treatment needs and service provision. According to the WHO (2013), in low- and middle-income countries, between 76 percent and 85 percent of people with mental health disorders will not get treated, a significant contrast from high income countries whose figures are between 35 percent and 50 percent.

The worldwide shortage of human resources for mental health occurs in both high-income and low-income countries, but happens to be more pronounced in low-income and middle-income countries (LMICs) (Kakuma, et al., 2011). The WHO (2011; 2013) and Bird et al. (2011) research showed that approximately half of the world's population is situated in countries where one psychiatrist could serve 200 000 people and where psychologists and other allied services have an even larger treatment gap. The treatment gap may also be the result of health systems prioritising the control and elimination of communicable diseases, particularly reproductive, maternal and child health, over mental health conditions (Charlson, Diminic, Lund, Degenhardt & Whiteford, 2014; Mugisha et al., 2017). A focus on communicable diseases leaves very few resources available for treating mental health conditions (Mugisha et al., 2017). However, it is understandable as such

diseases bear a higher risk of mortality (Gureje & Alem, 2000; Jenkins, et al., 2010; Mugisha et al., 2017)

A possible reason for this shortage in LMICs lies in the low percentage of mental health expenditure which affects mental health professionals in various ways (Jacob, et al., 2007; Szabo, 2013; Jack, et al., 2014). Szabo (2013) shed light on some of the factors explaining how each one contributed to the human resource shortage. For instance, trained specialists are often lost to more developed countries because of the perceived stability and improved working conditions offered (Szabo, 2013). Specifically looking at the African context, Szabo (2013) recommended that the pull and push factors need to be examined in detail in order to retain mental health professionals. The working conditions as well as the other factors will be explored in more detail later in this chapter.

Research has shown that, particularly in the African context, mental health policy development and implementation occur under challenging circumstances (Awenva, et al., 2010; Moteiro, 2015). There are several factors involved, some being that at times policy objectives do not match available resources, there is a lack of appropriate systems to deliver policy objectives and there is a lack of support for policy implementation (Petersen, Ssebunnya, Bhana, Baillie & MhaPP Research Programme Consortium, 2011; Monteiro, 2015; Smith et al., 2017). Monteiro (2015) reported that in some countries structures to implement policy are often non-existent, especially in rural areas. The scarcity of trained personnel also contributes to the problem of implementation because it means that there would be very few people to implement policy objectives (Smith et al., 2017). Funding too becomes problematic

because it has an impact on resource provision, which ultimately has an impact on service delivery (Smith et al., 2017).

While this may be the reality, there is limited research on the topic of mental health professionals in Africa in general (Reuter, McGinnis & Reuter, 2016). It is thus important to explore mental health issues in Africa because mental health contributes significantly to the global disease burden (Monteiro, 2015). As previously mentioned, very few countries in Africa have mental health policies and, not only that, the lowest mental health expenditure is in African countries (WHO, 2011; Reuter, McGinnis & Reuter, 2016). Most LMICs' spending on mental health is significantly lower than upper middle-income countries and high-income countries, with statistics showing US$ 1.53 per capita for LMICs, US$ 1.96 per capita for upper middle-income countries and US$ 58.73 per capita for high-income countries (WHO, 2014, as cited in Janse van Rensburg & Fourie, 2016). This is possibly due to the fact that LMIC health systems already have other apparently more pressing foci such as poverty, conflict, and communicable diseases such as HIV (Janse van Rensbburg & Fourie, 2016).

Of note, is the fact that populations with the highest level of socioeconomic struggle tend to have the least access to mental health services (Saxena, Thornicroft, Knapp & Whiteford, 2007; Daar et al., 2014; Monteiro, 2015). This simply means that there are several factors that prevent such populations from having adequate access to mental health services. One of the main challenges has to do with the lack of money (Swart, 2013; Monteiro, 2015). For instance, some patients, especially in rural areas cannot to afford to travel to the clinics or hospitals where mental health services are located (Swart, 2013; Monteiro, 2015). Part of this

challenge is that the health centres with mental health services are usually located far away from these populations (Swart, 2013; Atilola, 2014; Monteiro, 2015). According to Atilola (2014) and Eltayeb, Sliep and Muneghina (2017), a significant barrier to service provision is that most mental health services are concentrated in urban areas.

Most health systems in Africa are structured in such a way that small villages are served by health posts, while larger towns are serviced by health centres and district- or regional-level hospitals which provide specialist services based on referral (Alem, 2008, as cited in Monteiro, 2015). Ultimately those who cannot afford to go to a district hospital will not have access to specialist services (Monteiro, 2015).

2.3. Botswana's Mental Health Policy

Botswana, just like other African countries, faces similar challenges (Pheko, Monteiro, Kote & Balogun, 2013; Monteiro, 2015). Botswana is a Sub-Saharan country located in Southern Africa with a population of about two million people (Seitio-Kgokgwe, Gauld, Hill & Barnett, 2016). It shares international borders with South Africa, Namibia and Zimbabwe (Olwabi, 2012). Botswana has been hailed as one of Africa's success stories for diligently maintaining its democracy and for ruling with dignity and respect for its people (Olwabi, 2012). As a WHO member state, Botswana has developed a mental health policy which aims to improve the provision and delivery of mental health services (MOH, 2003). The policy's specific objectives are to establish decentralisation, integrate mental health services into general health services, and to ensure equal access to services (MOH, 2003). It also aims to improve the quality of mental health services by instituting relevant and accessible

legislation as well as targeted investment in services and resources to ensure adequate resource allocation (MOH, 2003).

This policy was established based on the mental health needs and mental health paradigm shift (MOH, 2003). Botswana's mental health needs, like those of other African countries, are a result of several psychological and social issues. Some of them include fast-paced urbanisation, the loss of extended family support, unemployment and socio-economic deprivation (MOH, 2003). These psychological and social issues have led to a culmination of mental health problems such as substance abuse, suicide, attempted suicide and other psychiatric conditions (MOH, 2003). Segopolo, Selemogwe, Plattner, Ketlogetswe and Feinstein (2009) reported an increase in schizophrenia and projected the likely increase of affective disorders in rural areas over urban areas. However no recent statistics have been found.

The paradigm shift refers to the decentralisation and integration of mental health services into general health services (WHO, 2010). Decentralisation means that mental health services are no longer restricted to psychiatric institutions, whilst integration means that mental health services are offered in public hospitals and clinics in order to provide better access to services (WHO, 2010). The paradigm shift developed out the recognition by the WHO that mental health contributed significantly to general health and well-being, and therefore should be incorporated into all aspects of health, specifically health settings (WHO, 1978).

The paradigm shift developed out of a global need to right the wrongs of the human rights violations that were inflicted upon people who suffered with mental illnesses (WHO, 2013). Historically, the institutionalisation of people with mental health conditions is filled with poor health outcomes, over-medication of patients and

generally poor living conditions within psychiatric hospitals (WHO, 2010; Drew et al., 2011). All over the world, mental health institutions have been overcrowded, unsanitary, overburdened and poorly managed (WHO, 2010).

The decentralisation of mental health services was established to relieve psychiatric institutions of the sole responsibility of providing mental health services, as well as to increase access to mental health services (Kigozi & Ssebunnya, 2009; Awenva, 2010; WHO, 2011; Jack et al., 2014). Through this shift, many countries have endeavoured to integrate mental health services into general health care, but mainly primary health care for more direct access to treatment (WHO, 2007a).

In Botswana, mental health services are provided in all district and primary hospitals around the country to increase access to mental health services (MOH, 2003). These services were introduced into Botswana's health system in 1980 as a pilot project and were formally established in 1992 (Maphorisa, Poggenpoel & Myburgh, 2002). In the earlier phases of decentralisation and integration, mental health units were run by community mental health or psychiatric nurses who were placed in general health facilities around the country (Maphorisa et al., 2002). Located in rural, semi-rural, semi -urban, and urban areas, the programme began as a pilot project with one psychiatric outpatient clinic run by a psychiatric nurse (Kgosidintsi, 1996). When the programme became successful, five other nurses were placed in health centres with the first outpatient clinic being established in the country's only psychiatric hospital (Kgosidintsi, 1996). Maphorisa et al.'s (2002) study on the experiences of psychiatric nurses revealed that the nurses felt discouraged, demoralised and disappointed by the general health system's response to mental health services.

The nurses' subjective experience was replete with misinformed health professionals, resistance and lack of support (Maphorisa et al., 2002). This may relate to the commonly known stigma against people with mental health conditions and biomedical bias within the health system (Van Wyk & Naidoo, 2006; Mkhize & Kometsi, 2008; Janse van Rensburg & Fourie, 2016; Bugess, 2016). For many years, people with mental health conditions have been discriminated against and perceived as violent, aggressive and a danger to society (WHO, 2010; 2013). Not only is this perception held by the general population, it is also held by health professionals (WHO, 2010; 2013). In many ways, this perception has led to the poor treatment of such patients and marginalisation of mental health in general (Van Wyk & Naidoo, 2006; WHO, 2013).

The biomedical bias refers to the dominating principle that treating physiological symptoms is more important than the psychosocial needs of patients (Van Wyk & Naidoo, 2006). It is the belief that it is easier to treat medically exhibited symptoms, even when doing so is not beneficial to patients (Hanlon, et al., 2016). On the other hand, working with the biomedical model seems more efficient because this approach immediately subdues unwanted symptoms and therefore seems to work (Hanlon, et al., 2016). From this perspective, it is easy to understand why many health systems prioritise medical approaches over psychosocial ones. It could be a possible explanation for the resistance to mental health treatment and the low mental health budgets within health systems (Seloilwe & Thupayagale-Tshweneagae, 2007). At the same time it is important to note that medical practitioners and mental health practitioners are trained separately and socialised to view illness from different perspectives (McDaniel & DeGruy, 2014) . They also have limited opportunities in training to work together (McDaniel & DeGruy, 2014).

This could possibly explain why it may be challenging for a collaboration to occur (McDaniel and DeGruy, 2014).

2.4. Botswana's Health System

Botswana's health system encounters similar difficulties. To gain a better understanding of Botswana's mental health context, it is first important to understand how its health system operates. In Botswana, the government, through the Ministry of Health, is responsible for a large percentage (98%) of health care provision with the assistance of private institutions, non-governmental organisations, the mining industry and faith-based organisations (Owolabi, 2012). Primary and secondary health care facilities are located in towns and villages whilst tertiary facilities are located in cities (Seloilwe & Thupayagale-Tshweneagae, 2007). The majority of the population is located within a 5- to 11-kilometre radius of a public health facility, which is an indication that most of the population has access to public health facilities (Owolabi, 2012).

At the primary level, there are mobile stopping points. This is followed by health posts which are operated by a nurse and a family welfare educator and reaches approximately 500 people. Next is the clinic, which reaches about 4000 people with a staff of community health nurses and a sessional medical practitioner. Some clinics have maternity wards and laboratories and operate 24 hours. At the secondary level there are primary and district hospitals which provide both outpatient and inpatient services. At the tertiary level there are referral hospitals with specialist services. There are three referral hospitals in Botswana, one in Gaborone, the capital city, one in Francistown, and one of them is the country's only psychiatric hospital in Lobatse (Seloilwe & Thupayagale-Tshweneagae, 2007).

Although most of the population has access to health care facilities, Seitio-Kgokgwe, Gauld, Hill and Barnett (2014) point out that there are several challenges in service delivery. Some of the challenges include problems with budget allocation, shortage of specialised mental health practitioners such as psychologists and psychiatrists, and lack of resources (Seitio-Kgokgwe et al., 2014; Nkomazana, Peersman, Willcox, Mash & Phaladze, 2014).

Seitio-Kgokgwe et al. (2016) conducted an analytical study of Botswana's health system based on the WHO Health System Performance Assessment Frame (HSPAF). Their study aimed to assess governance, also known as stewardship, of Botswana's health system. The term stewardship refers to public and political decision-making processes as well as the institutions and instruments under the government's authority (Saltman & Ferroussier-Davis, 2000). The study focused on the themes of health policy development and implementation, regulatory practices, and stakeholder collaboration, with the purpose of analysing their impact on service delivery (Seitio- Kgokgwe, Gauld, Hill & Barnett 2016). The study revealed that policy development and implementation was forestalled by shortages in human resources at both managerial and technical levels, with limited supervision and policy guidelines (Seitio-Kgokgw et al., 2016). One of the main concerns was related to the decentralisation. Through decentralisation, the MOH relegated primary healthcare responsibilities to the Ministry of Local Government. This hand-over was challenging because of the little guidance that was given along with inadequate resource allocation. As Seitio- Kgokgwe, Gauld, Hill and Barnett (2016) put it, when the MOH let go of primary health care, resource allocation fell behind and there was no monitoring of the process. In terms of the policy implementation, Seitio-Kgokgwe et al. (2016) stated that there were some challenges with policy implementation, the

reason being the unclear guidelines for service delivery. Although this may have been the case, the MOH did provide some training and support to enhance implementation and adherence to policy standards (Seitio- Kgokgwe et al., 2016). Bearing this in mind, they did not explore the implementation of the mental health policy explicitly as they mainly addressed what occurred in the public health setting as a whole. It could be inferred that mental health professionals within in this setting may face similar situations.

The abovementioned study was useful in elucidating some of the challenges faced within the public health setting, a setting that also employs mental health professionals. The main purpose of the current study is to explore the experiences of psychologists as mental health practitioners in public health facilities. The issue of policy implementation and development is of particular relevance in the current study because it provides a systemic view of the public health setting and its structures. It is also relevant because it informs daily practice and service provision. The authors recommended improvements in leadership, monitoring and evaluation for a more effective health system.

The next section of the literature review addresses the experiences of psychologists in the public health settings. The main motivation for focusing on this particular setting in Botswana is because the primary employer for health professionals in Botswana is the Botswana government (Nkomazana, Peersman, Willcox, Mash & Phaladze, 2014). Not much is known about the experiences of psychologists in Botswana or their in experiences in a public health setting. There is also limited research on the experiences of psychologists in public health facilities in

general. What can be explored however, are similar settings in the African context. This means extracting examples and experiences from other LMICs.

2.5. Mental Health in Africa

A study was conducted in Ghana by Awenva et al. (2010). They identified key barriers to mental health policy implementation and revealed that mental health was of low priority in the health system, especially because the system prioritised other medical conditions. This view was shared by mental health professionals and policy makers in their study (Awenva et al., 2010). The study highlighted a number of barriers, such human resource shortages, financing, consultation between professionals and knowledge and education (Awenva et al., 2010). One respondent's account of the human resource shortage was that there were not enough community psychiatric nurses to manage patient recovery and re-integration into society. This led to a heavy reliance on medication and institutionalisation of patients (Awenva et al., 2010). This was attributed to the shortages of allied mental health professionals such as psychologists, occupational therapists and psychiatric social workers who would facilitate psychosocial, rehabilitative and preventative interventions (Awenva et al., 2010). This was supported further by the WHO's (2011) report on the scarcity of allied mental health services in LMICs.

The financial difficulties found were similar to those in most African countries and LMICs where a small percentage, between one percent and four percent of the health budget, was allocated to mental health (Kigozi & Ssebunnya, 2009; Awenva et al., 2010; WHO, 2011; Lund, Petersen, Kleintjes & Bhana, 2012; Monteiro, 2015; Smith et al., 2017). Awenva et al. (2010) found that there was no designated mental health budget which created difficulties for overall planning and resource allocation.

Funding affected a number of areas, such as in-service training, provision of medication, maintenance of infrastructure and other resources such as transportation, a view expressed by one psychologist in the study (Awenva et al., 2010). The consultation between professionals refers to the communication about daily practice and policy plans which, according to the respondents, were lacking and affected daily practice because the proposed plans did not align with the day-to-day service delivery (Awenva et al., 2010). Lastly, a common view was that more education, more mental health professionals, and research and training were needed to improve the mental health system (Awenva et al., 2010).

Awenva et al.'s (2010) study reflected what most studies have concluded. Although it may not be a recent study, it still reached similar conclusions. For instance, Monteiro's (2015) more recent study identified similar challenges, stating that there were not enough specialists in most African countries to treat, diagnose, assess, monitor and manage psychological conditions.

These problems were also identified by Smith et al. (2017) in Rwanda where 42 district hospitals were each serviced by one psychologist and one psychiatric nurse. This particular context was different in that the mental health structures were reconstructed after conflict and genocide. Such a context could possibly put the society at a greater risk for developing mental health conditions such posttraumatic stress disorder, depression, substance use disorders and anxiety disorders (Smith et al., 2017). Burundi has a similar context, being a densely populated country like Rwanda, with a history of conflict and genocide. The status of a low-income country would also possibly place the society at greater risk for developing mental health conditions (Ventevogel, Ndayisaba & van de Put, 2011). This is because war and

conflict can result in social problems such as sexual violence, displacement of people and loss of traditional values and ruptured social systems (Ventevogel, Ndayisaba & Van de Put, 2011). These circumstances would create a greater need for mental health services (Ventevogel, Ndayisaba & Van de Put, 2011).

A recent study by Mugisha et al. (2017), assessing mental health systems in six LMICs, India Nepal, Nigeria, Uganda, Ethiopia and South Africa, aimed to identify the main barriers to mental health service delivery. The study undertook to provide evidence-based solutions for efficient mental health service delivery in a project called the 'Emerging mental health systems in low and middle-income countries' (EMERALD) programme. This project confirmed the abovementioned challenges, possibly highlighting a trend in mental health service provision within Africa and other LMICs. Although India and Nepal are not African countries, their results are considered as valuable information and as data that can be contrasted with African countries. The EMERALD programme is an international project which ran from 2012 to 2017, focusing on a number of pertinent elements based on the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS). This included mental health legislation and human rights, human resources, financing, mental health policy, HIV/AIDS and mental health, availability of mental health services, maternal health, mental health, and monitoring and evaluation (Semrau, et al., 2015; Mugisha et al., 2017).

The EMERALD results showed that legislation in all participating countries had either recent mental health acts or old mental health acts under revision, which could be a sign that mental health was receiving the necessary legal attention (Mugisha et al., 2017). These acts and bills were in accordance with the United

Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), and were included in the study countries' national Constitutions (Mugisha et al., 2017). In terms of mental health policy, the EMERALD study showed that South Africa had a more recent Mental Health Policy and Strategic Plan (2013-2020). Nepal had a Mental Health Policy (1996), which had not been in effect for fifteen years, with no office at the Ministry of Health and Population in Nepal. Uganda had a draft mental health policy which was awaiting approval at the Ministry of Health while Ethiopia did not have a mental health policy, but instead had a Mental Health Strategy (2012-2016), and Nigeria had a revised Mental Health Policy (2013).

Similar to previous studies, Mugisha et al.(2017) noted the same human resource shortages, which produced the ratios of psychiatrists, psychiatric nurses, doctors and nurses per 100 000 people. All across the study countries mental health professionals were in short supply, ranging between 0.5 and 10.08 per 100 000 people, with the highest concentration of professionals being psychiatric nurses in South Africa at 10.08 per 100 000 people. This shortage contributes largely to the treatment gap in many LMICs (Saxena, et al., 2007; Kakuma et al., 2011; Smith et al., 2017). Kakuma et al. (2011) pointed to some substantial issues that maintained the human resource shortage. These involved issues in recruitment, staff attrition, financing and leadership. As far as recruitment is concerned, even at the level of training not enough students enrol for mental health professions such as psychiatry, and, even so, the negative perceptions held about mental health keep potential mental health professionals away (Kakuma et al., 2011).

The loss of mental health professionals from low-income countries, including in Africa, to high-income countries has been observed in several studies and has

been said to cause a significant drain to health systems (Kakuma et al., 2011; Szabo, 2013; Reuter, McGinnis & Reuter, 2016). This is partly because a large number of these countries do not have specialised training programmes in mental health, which leads to eventual relocation (Szabo 2013; Reuter, McGinnis & Reuter, 2016). In addition, most mental health professionals work in public health facilities as government is the main service provider and employer, and staff attrition occurs as a result of demoralising and demotivating resource limitations and working conditions (Omar et al., 2010; Szabo, 2013; De Sousa & Dela Coleta, 2015). The end result is rural to urban migration and migration to high-income countries in search of better working conditions (Szabo, 2013; Monteiro, 2015).

The financing issues have been reiterated by numerous studies which continuously present evidence of low expenditure and low prioritisation of mental health (Saxena et al., 2007; Kigozi & Ssebunnya, 2009; Jenkins et al., 2010; Petersen et al., 2011; Hanlon et al., 2016; Smith et al., 2017; Mugisha et al., 2017). It cannot be stressed enough how detrimental the financing issues are to the development of mental health as whole, and what a significant contribution they make to the resource deficits and treatment gap (Szabo et al., 2017). This seems to be a universal concern across all studies. Not much is said about the state of leadership in the research except just to note a few programmes that have been implemented to develop effective leadership (Kakuma et al., 2011; Szabo 2017).

Looking back at Mugisha’s et al. (2017) results, Nepal, a low-income country, and India, a lower-middle income country, seemed to share the same challenges that most LMICs do. They seemed to share common resource shortages and problems within the mental health system. As far as differences go, there seems to

be no difference between LMICs in Africa and LMICs in other continents (Saxena et al., 2007; Kakuma et al., 2011; Reuter, McGinnis & Reuter, 2016).

2.6. The role of Psychologists in Public Health Facilities

Mental health care is narrowly understood as psychiatric care under the dominant biomedical model in most health settings. However, in the broad sense, it incorporates a holistic sense of well-being, from the emotional and spiritual to the physical (WHO, 1978). This has presented an opportunity for psychologists to become a part of the health setting. In an effort to incorporate this holistic view a space was created for psychologists as mental health professionals to address the psychological components of physical illness and its psychological effects (McDaniel & DeGruy, 2014). Not only that, but their presence in the health settings allows for better access to mental health services (McDaniel & DeGruy, 2014). This is necessary for better management of conditions and cost-effective health care provision. The holistic model of health care provision is meant to cater to the needs of the population by providing a first point of access to mental health services (Swart, 2013). The psychologist's role in this setting is to become a link for patients in the health settings, and ensuring treatment adherence by attending to the psychological aspects of diagnosed conditions medical and otherwise, such as cultural, familial, emotional and behavioural issues (McDaniel & DeGruy, 2014).

There are several professional responsibilities that the psychologist can adopt, and this is due to the flexible nature of psychology (McDaniel & DeGruy, 2014). Firstly, one can be member of a multidisciplinary team collaborating with both patients and clinicians to reach better health outcomes. As experts in human behaviour and emotion they can be facilitators in the treatment process, helping

patients to understand their medical diagnosis and develop coping strategies to manage their condition. Secondly, they are behavioural consultants helping other clinicians to understand the psychological aspects of treatment, assisting with treatment planning and developing skills to broaden their scope. Thirdly they are involved in treatment monitoring which involves a systemic view that engages family members and the whole health system Directorate of Public Service Management (DPSM) (DPSM, 2013)

Depending on the level of experience and expertise, the psychologist can operate as a team leader whose role is to facilitate change, monitor and improve the quality of services, run meetings and collaborate with other professionals in problem-solving and decision-making. As the head of a psychology department, the psychologist participates in monitoring treatment outcomes, promoting practical policies and creating a conducive work environment for psychologists and managing the departmental budget (DPSM, 2013). Psychologists can also be part of practice and evidence-based research, providing a knowledge base for improved psychological practice (DPSM, 2013). These duties are not unique to Botswana's health setting. They are ubiquitous to psychological practice around the world.

The abovementioned roles and responsibilities are envisioned practice guidelines for optimal psychological practice. However, in reality there are certain challenges that can impede optimal practice. Little is known about the psychologist's experience in the health setting, more so in the public health setting. These challenges and other work-related factors will now be addressed by looking specifically at what the literature says about the experience of working in a public health facility.

2.7. Psychology as Practiced in Botswana

There are several factors at play. One in particular was addressed in a study by a Motswana psychologist, July (2009). It related to the awareness, attitudes and referral practices to psychological services. The aim of the study was to explore the health professionals' understanding of the psychological services offered in their hospitals. The participants were doctors, nurses, social workers, psychiatric nurses and one psychiatrist. The study revealed that there was a shortage of psychologists and, due to this shortage, most of the health professionals ended up assuming the role of a psychologist (July, 2009). This, as July (2009) stated, resulted in role confusion. July's (2009) findings also demonstrated that most participants were of the opinion that psychological services were not easily accessible to the public, mainly because psychologists were located only in referral hospitals.

Consequently medical doctors and nurses in clinics and other health settings become tasked with psychological responsibilities. Such responsibilities fall out of their scope which leads to inadequate assessment and treatment of psychological cases (July, 2009). Reliance on doctors and nurses alone for such services could potentially be demanding for these professionals (July, 2009). When asked what treatment methods were employed to manage psychological cases, most participants said they responded by medicating patients. This seems consistent with the biomedical model. Additionally, the study showed that respondents recognised the clear distinction and importance of psychological services and were willing to make the necessary referrals to psychologists when they were available.

Evident in this study was that there is a shortage of psychologists in public health facilities and this can be attributed to the general scarcity of such

professionals in Botswana (Plattner & Moagi-Gulubane, 2010). Psychology in Botswana is a relatively young profession with about 0.3 psychologists per 100 000 people (Pheko et al., 2013). No recent studies have been conducted thus far to rate the growth of psychology in Botswana. Psychologists register through the Botswana Health Professions Council (BHPC) and are regulated by the Botswana Association of Psychologists. The association is also growing slowly (Plattner & Moagi-Gulubane, 2010; Pheko, Monteiro, Kote & Balogun, 2013). All psychologists are trained abroad as professional training in psychology does not yet exist (Plattner & Moagi-Gulubane, 2010). Further inquiry revealed that there is still no professional training at present. Some work in the private sector, others in non-governmental institutions, whilst others work at the University of Botswana and some work in government ministries (Plattner & Moagi-Gulubane, 2010).

2.8. Experiences of Psychologists in Public Health Facilities

As has been shown, the public health facility is a place with many challenges. These challenges are brought on by a lack of resources, at times mismanagement of funds and poorly maintained infrastructure. This phenomenon is not unique to developing countries, it is a worldwide situation (Safarjan, 2002; Yanchus, Periard, Carle & Osatuke, 2015) . In addition, the population served in public health facilities brings its own unique set of challenges. The population consists mostly of disadvantaged communities. Most people in this population have low family incomes, long histories of chronic illness, live in impoverished neighbourhoods and have histories of abuse and neglect (Safarjan, 2002; Swarts, 2013). Such a context makes people more vulnerable to developing emotional and behavioural difficulties (Mkhize & Kometsi, 2008; Swarts, 2013). Swarts (2013) emphasised the importance

providing good quality psychological services so as not to intensify the already existing vulnerabilities.

Swarts' (2013) study is was personal reflection of her experience as a clinical psychologist in community service. She gave a detailed account of her experience in the Overberg District Municipality, a small area in Cape Town, South Africa. Her placement in the district was a policy imperative established by the South African National Department of Health to enable better access to mental health services and to serve as development and training for new graduates in the health profession (Pillay & Harvey, 2006). This is known as community service, where clinical psychologists are placed at public health facilities to offer psychological services (Pillay & Harvey, 2006)

Swarts' (2013) study was especially helpful in explaining the different levels from which quality could be viewed. From a policy stand-point, which is informed by the WHO (2003), quality refers to a measure of whether the provided services lead to effective treatment outcomes. From the patients' viewpoint, quality refers to symptom reduction and an enhanced quality of life, as well as positive outcomes for their families (WHO, 2003). For the service provider, quality refers to the provision of effective and efficient treatment outcomes and an overall improvement of service delivery (WHO, 2003). For the policymaker, quality refers to improved mental health for the population as well as equitable management of resources (WHO, 2003). The ideal execution of quality services, as defined by the WHO (2003), is when limited resources are used in an efficient and effective way which inspires trust in the health system.

Swarts (2013) engaged in a discussion about the relevant practical implications of providing psychological services to an underserved community with limited resources. She found that it was not financially viable for patients to attend the therapy sessions because they had to work . Most of the population consisted of seasonal farm workers whose income was determined by an hourly wage system which meant that missing hours of work resulted in no pay. Circumstances such as these led to untimely termination of therapy.

The systemic challenges faced by most mental health systems manifest at the level of service delivery affecting both the clinician and the patient (Swarts, 2013). In Swarts' (2013) study, she was the only clinical psychologist servicing eleven primary health care clinics within three municipalities. Without a psychiatrist or mental health nurse, Swarts was the only mental health specialist in the area which meant that all mental health related issues were referred to her. As a result, she had a high caseload and was only able to see her follow-up patients every four to six weeks. Swarts (2013) was concerned that this type of situation led to poor treatment outcomes as the patients who needed frequent therapeutic contact did not get it and would often have to return at a point of crisis. In this case the quality of service was compromised, leaving the treatment needs of the target population unmet (Swarts, 2013).

Swarts' (2013) study was extremely insightful in that it provided both a systemic view as well as a personal reflection of her experience. She highlighted the practical drawbacks involved in providing psychological services such as problems with receiving correct referrals, lack of in-patient psychiatric facilities, lack of appropriate supervision, and lack of institutional support. As a recommendation,

Swarts (2013) emphasised the importance of establishing a supportive framework at both the policy and institutional level focusing specifically on the quality of mental health service provision.

In similar studies, Padfield (2013) and Padfield (2015) provided her personal account of being an itinerant clinical psychologist in community service. Her site was located in the Boland-Swartland area of the Western Cape, South Africa. She rotated between five primary health care clinics within disadvantaged communities. As the only clinical psychologist, Padfield (2013) felt professionally isolated and described something she called, “The disappearing therapist.” This means that she was ignored by other staff members and felt invisible. With no office space provided for her at the beginning of the community service, Padfield (2015) felt “institutionally” and “physically” excluded. To create her own physical space, Padfield (2015) used a small table from the staff room and brought her own chair from home. She also had to endure constant disruptions during therapy from nursing staff in search of office supplies. Institutionally, she said there were no preparations or standard procedures for daily practice or clear role definitions for other staff members such as nurses for appropriate referrals (Padfield, 2015). She did, however, mention that even under such challenging circumstances there was some symptom reduction for patients and that it was possible to make use of limited resources to provide effective brief psychotherapeutic interventions.

Also in South Africa, a study by Pillay, Kramers-Olen, Kritzinger and Matshazi (2012) on the experiences of clinical psychologists in public health facilities demonstrated that, even with resource limitations, two-thirds of their participants were satisfied with their clinical work. Pillay et al. (2012) reported that these results

suggested that participants were coping with the challenges and were adjusting to the clinical needs. On the other hand, one third felt unsupported whilst the rest felt supported in the work environment (Pillay et al., 2012).

A situational analysis of clinical psychology services in rural primary health care settings in South Africa has revealed that over the last 20 years there has been an increase of clinical psychologists in the public health sector (De Kock & Pillay, 2017). De Kock and Pillay (2017) have taken this as an indication that access to psychological services has increased. This could suggest that in spite of the challenging environmental factors within the public health setting, there has still been a commitment to psychological service provision.

2.9. Conclusion

It is evident from the literature reviewed that systemic processes play a vital role in the delivery of psychological services and mental health services in general. Not much is known about psychological service provision, especially in the African region. Only limited research on the experiences of mental health service providers exists. It was challenging to locate studies that specifically targeted the experiences of psychologists. The lack of recent evidence on this topic possibly indicates that more research is required. However more studies about mental health became available when the specific focus became the public health setting. This could be because the government is the main employer of mental health specialists, as noted in several studies (Semrau, et al., 2015; Janse van Rensburg & Fourie, 2016; Mugisha et al., 2017). In addition, several studies were collaborative studies, some with the WHO programmes, analysing government data, with the knowledge that statistically government as the main service provider would have national data on

mental health. This seemed to be the case for most African studies, and such was the case for Botswana. Numerous studies derived their data from WHO reports which had statistics on global and country-specific human resource ratios, policies, expenditure and treatment gaps.

As several research studies have shown, the international commitment by the WHO and its member countries to improve mental health services has been ongoing. Challenges with policy implementation have been observed in many LMICs and these hamper service delivery. It could not be overemphasised by the research how damaging limited mental health expenditure was to all aspects of development. The human resource shortages contributed significantly to the treatment gap and multiple issues regarding training, staff attrition and, most importantly, financing were involved in maintaining the problem.

With all these variables considered, from a systemic point of view, it could be argued that these factors may have an impact on the experiences of psychologists in public health facilities. The systemic theoretical framework will be explored in more detail in Chapter Three. It was found that the public health setting is a demanding work environment especially with all the resource limitations. It was also found that even with these challenges, there was a commitment to patient care and that psychologists were satisfied with their clinical work.

Chapter Three: Methodology

3.1. Introduction

The literature review in the previous chapter laid out the scope and aim of the study. This chapter describes the methodological decisions that were made for the current study. The theoretical framework provided an explanation of contextual factors. This chapter also offers a description of the paradigm that was used and how it informed the methodology. It also describes the methodology and how it was used to answer the research question. The methods are outlined as well as the ethical issues that were considered.

3.2. Theoretical Framework

The ecological systems theory is used as a framework for understanding the context in which psychologists work. The theory states that human behaviour is influenced by factors within the environment (Bronfenbrenner, 1994). An individual is placed within five different levels of a system. These five levels consist of the microsystem, mesosystem, exosystem, macrosystem and chronosystem. These levels are embedded within each other with the microsystem in the centre and the chronosystem as the outermost layer. The microsystem is the immediate environment, where the main social interactions occur (Bronfenbrenner, 1994). For the psychologist, this would be the immediate work environment in which most professional relationships are based. Direct contact is made with patients, doctors, nurses, social workers, psychiatrists and occupational therapists.

The mesosystem is the level where microsystems interact (Bronfenbrenner, 1994). This entails collaborations between the psychologists' department, other departments and other organisations. The exosystem is the broader social system (Bronfenbrenner, 1994). This would include the hospital as whole, its procedures and regulations. The macrosystem includes the wider network of social systems such policies, legislation and cultural values. The macrosystem ultimately affects individuals even though they do not participate in it directly (Bronfenbrenner, 1994). Lastly the chronosystem includes the events and changes that have occurred over time (Bronfenbrenner, 1994). For example, a monumental event such as policy implementation or the development of a new structure within a system could have an impact on one's psychological practice. This theory is particularly useful for this study because it outlines both individual and contextual factors and how they may interact to influence the individual (Eriksson, Ghazinour & Hammarstrom, 2018).

3.3. Epistemology and Ontology

The current research study was based on the interpretivist paradigm. Its ontological assumption, meaning its understanding of reality, is that reality is both objective and subjective (Della Porta & Keating, 2008). In this sense, interpretivists believe that reality is constructed by both the observer and the observed. They also believe that there is no one single objective reality and therefore no right or wrong theory (Blaikie, 2004). This is because interpretivists assume that there are multiple ways for individuals to experience the same reality (Willis, 2007). It is assumed that reality can only be known by asking those experiencing it.

Its epistemological assumption is that knowledge is gained by learning about the meanings that people attribute to a particular experience (Schwandt, 2007). The

aim of the interpretivist is to understand social phenomena by observation and interpretation. Social phenomena are understood by analysing social constructs such as language, opinions and behaviours (Silverman, 2001). Qualitative methods rather than quantitative methods are used. It is believed that knowledge is gained through an in-depth exploration of a chosen subject (Walsham, 2006). A research study using this paradigm would most likely use an in-depth interview, observation or other qualitative methods to collect data. Once data are collected, the researcher makes interpretations by making meaning of what was said or observed. It is believed that knowledge production is contextual. This means that each different type of knowledge is dependent upon time, person and place (Della Porta & Keating, 2008).

Interpretivism has an adaptive approach to researching various experiences. There are no right or wrong ways to gain knowledge. Iterative and emergent strategies are utilised throughout the research process (Tullis Owen, 2008). This is to allow as much knowledge as possible to be gained. An advantage to using this paradigm is its flexibility and its ability to access a great amount of knowledge in detail. Participants are viewed as active agents in knowledge production whose experience is regarded as expert knowledge on the studied subject (Della Porta & Keating, 2008). The researcher plays an active role as an inquirer and as a collaborator in knowledge production (Roberts, 2007). The research paradigm has an influence on the whole design of the research study (Carter & Little, 2007). It determines how participants are viewed, the researcher's role, and the methodology (Carter & Little, 2007).

This paradigm is aligned with the aim of the study which is to explore the experiences of psychologists working in public health facilities. Psychologists

working in public health facilities are considered to be the ideal participants because they are well-informed through their experience of working in a public health facility.

3.4. Methodology

3.4.1. Qualitative Research

The qualitative research approach was chosen for the current study. This research approach is aligned with the interpretive research paradigm. The qualitative approach aims to understand and make meaning of the social world rather than focus on cause and effect (Braun & Clarke, 2013). Qualitative research is used to understand how people experience different situations and how they manage certain situations (Willig, 2013). According to Mason (2002), it is a focus on the texture, complexity detail and depth of experience. It is understood that there are variations to the same experience, and qualitative researchers expect these variations in data collection and analysis (Braun & Clarke, 2013). Qualitative research is a context-based approach and, as such, research is carried out in participants' natural settings (Atieno, 2009). Various contextual factors such as the environment, culture, norms, roles and values have an impact on the participants' experiences and this is why it best to capture the data in a natural setting (Marshall & Rossman, 1999; Atieno, 2009). Knowledge from previous studies or literature cannot be used to make interpretations (Creswell, 2014). However, previous literature can help to provide a focus and define the aim of the study.

3.4.2. Research Site

The research topic was based on an experience located in the public health facility which made this context particularly important to the study. This context was

accessed through the selection of participants and the formulation of interview questions.

Access to the public health facility was gained through ethical clearance from the public health facility. This enabled the researcher to conduct two interviews in the public health facility. The third interview was conducted at each participant's private practice. However, the subject of discussion connected the participant back to her experience of the public health setting.

3.4.3. Research Environment

Ideally a deeper meaning of a participant's lived experience is captured through face-to-face interactions (Marshall & Rossman, 1999; Creswell, 2014). It is argued that human behaviour cannot be understood without context (Tullis Owen, 2008). To understand what participants are saying the researcher needs to be exposed to that very environment (Norum, 2008). To capture the true meaning, the researcher needs to stay as close as possible to what participants have said (Creswell, 2014).

It may not always be possible to conduct interviews in all settings. Interviews can be conducted at the participant's home, restaurants, coffee shop or other locations that are chosen by participants (Norum, 2008). This still allows the researcher to get close to the experience even when the setting is not available.

3.4.4. Research Design

This study adopted an exploratory design. It was not designed to make any conclusions or formulate any theoretical assumptions, but rather to learn more about the lived experience and to accumulate as much knowledge as possible.

To accommodate new information, concepts and ideas, qualitative research takes on an emergent design (Flick, 2018). If certain methods do not work during the research process, the design is flexible enough to accommodate new methods (Flick, 2018). In this way, qualitative researchers work inductively and deductively (Marshall & Rossman, 1999). This means that categories and themes are data-driven (inductive) and then later those themes and categories are reviewed to see if they are based on evidence (deductive) (Creswell, 2014). If more information is needed more data can be collected (Creswell, 2014).

During this process, the researcher must be aware of their influence in the research process and must be explicit about her or his assumptions (Creswell, 2014). Prior knowledge or experience with the research problem by the researcher must be stated (Marshall & Rossman, 1999; Creswell, 2014). With these factors in mind, the researcher has to be aware how the selected research methods may influence the data and how personal experience may influence the data (Braun & Clarke, 2013).

The qualitative research approach is well matched to the study's intention. Its methods help to answer the research question appropriately. This research is concerned with answering a question about lived experience. A qualitative approach is designed to do that. Marshall and Rossman (1999) outline the strengths to be that it is research that provides an in-depth exploration of complexities and processes, research that can be used when little is known about a particular issue, and research that can ask questions about the disparity between policy and practice. Mason (2002, p. 1) provides an apt description when she says, "This means that it has an unrivalled capacity to constitute compelling arguments about how things work in

particular contexts". It would benefit the study to do all of the above. As indicated in the previous chapter, not much is known about the research topic. Any knowledge that is gained will make a contribution that can then be used for further study.

3.4.5. Limitations

A limitation to qualitative research is that the findings cannot be generalised to a larger population (Atieno, 2009). As Mason (2002) argues, statistical significance is not the aim of qualitative research. Its aim is to understand the social world in context, where quality and detail offer more to the research than quantity.

According to Atieno (2009), another limitation is that misinterpretations are inevitable because of the ambiguities in the human language. This may be true. However, Mason (2002) argues that these complexities are embraced and used in the analysis to provide explanations. As Braun and Clarke (2013) and Mason (2002) argue, methodological challenges are inevitable with all methodologies. However, the shortcomings may be due to how the methods are used rather the methods themselves. Still, the limitations can be managed through a thorough reflexive process (Braun & Clarke, 2013).

3.5. Method

3.5.1. Sampling

A purposive sampling approach was used to recruit participants in this study. Purposive sampling, also known as expert sampling or judgmental sampling, is a type of non-probability sampling (Battaglia, 2011). This type of sampling was selected for its ability to provide information-rich cases (Patton, 2015). This means that the researcher intentionally chose individuals who could give an in-depth

description of the phenomenon under study (Creswell, 2007; Patton, 2015). A purposive sample is one that is deemed to represent the population of interest accurately (Battaglia, 2011). The intention was to choose a sample that would ultimately answer the research question and provide a deeper understanding of the research problem (Creswell, 2014). In addition to answering the research question, purposive sampling also has the capacity to present contrasts and comparisons within the research data (Palinkas, et al., 2015).

Through purposive sampling the researcher recruited three participants, two male clinical psychologists and one female clinical psychologist. Both male clinical psychologists were then employed by a public health facility whilst the female clinical psychologist was a former employee of the public health system. These participants were chosen for their expert knowledge on the experience of working in a public health facility as clinical psychologists. The government of Botswana only recruits clinical psychologists which is why only clinical psychologists were selected (DPSM, 2013). For the sake of variability within the sample, the researcher had aimed to recruit both incumbent and former employees of a public health facility. The age range was between 25 and 60. The criterion of work experience ranged from one year of experience to ten years of experience either previous or current. These criteria were chosen based on one factor, mainly that the recruitment of psychologists in public health facilities was relatively new and because it was new, most likely participants would have had a maximum of ten years of experience.

The first male participant was foreign clinical psychologist from Bangladesh with nine years of experience whilst the second male participant was also a foreign clinical psychologist from Bangladesh with nine years of experience. The female

participant was a Motswana clinical psychologist with ten years of experience in the public health setting.

3.5.2. Health Facilities Used

Once ethical clearance was obtained (please see Appendix A, Appendix B, and Appendix C), two public health facilities were approached for permission to conduct the study. It was initially hoped that for maximum variability four public health facilities would be approached, but due to time and resource limitations only two facilities were approached. Due to time constraints only one public health facility was able to grant ethical clearance. A letter was sent to the hospital management of both facilities requesting permission to conduct interviews with their clinical psychologists. The hospital management was also requested to forward information letters to potential participants so that they would be adequately informed about the research purpose and their requirements as participants. Contact was made with prospective participants to build rapport and to establish a willingness to participate. In this communication, participants were informed that their participation was voluntary. The participants signed an informed consent letter as ethical confirmation of their participation (Please see Appendix D).

3.5.3. Data Collection

A semi-structured interview focusing on contextual and work-related demands, and the experience of working in a public health facility was conducted with each participant (please see Appendix E). The duration of the interviews was between forty-five minutes to an hour. The interviews were recorded and transcribed. This method of data collection is useful because it allows the researcher to access large amounts of data in short space of time (Marshall & Rossman, 1999). Through

this method, participants can provide historical information (Creswell, 2014). This was an advantage for the research, especially because there was very little documentation of the topic in Botswana. In addition, semi-structured interviews are flexible enough to allow the researcher to explore any new information that may arise or to focus on any topics that seem important to participants at the time (Gill, Stewart, Treasure & Chadwick, 2008). A benefit of using such a method is that direct access to information is gained from the source (Mason, 2002). Clinical psychologists would be able to give detailed accounts of their experiences of working in a public health facility.

3.5.4. Data analysis

The data were analysed using thematic analysis. Braun and Clarke (2006) describe thematic analysis as a method of finding patterns within the data, analysing and reporting on them.

Thematic analysis is considered the foundation of most data analysis methods in qualitative data analysis (Braun & Clarke, 2006; Willig, 2013). The researcher actively searches for themes that seem important to the research topic (Kellehear & Gliksman, 1997, as cited in Fereday & Muir-Cochrane, 2006). Themes are identified by a thorough reading and re-reading of the data (Rice & Ezzy, 1999, as cited in Fereday & Muir-Cochrane, 2006). Fereday and Muir-Cochrane (2006) describe it as type of pattern-recognition that creates categories of analysis through the identified themes.

Thematic analysis is flexible enough to be used with any theoretical framework (Braun & Clarke, 2006; Maguire & Delahunt, 2017). The themes in this study were aligned with the ecological systems theory. In this process of organising

and categorising data, it was important to establish what counts as a theme (Braun & Clarke, 2006; Willig, 2013). Braun and Clarke (2006, p. 82) define a theme in this way: “A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set”.

Willig (2013) describes thematic analysis as a process in which the researcher interprets the comments of participants and makes meaning of them. Reoccurring statements by participants are then grouped under a particular label to create a category (Willig, 2013). The theme also depends on what the research question is and also on the type of interpretation the researcher does. The researcher could choose to focus on the content, the expression of content or on the emotional responses to questions or all of these (Joffe, 2012; Willig, 2013). Thus, themes can be derived from obvious observable spoken statements known as semantic themes, or from implied meanings such as the mode of expression known as latent themes (Braun & Clarke, 2006; Joffe, 2012; Maguire & Delahunt, 2017).

There are different ways to derive themes. An inductive or deductive approach can be used (Boyatzis, 1998). An inductive approach is data-driven whilst a deductive approach is theory-driven (Boyatzis, 1998). An inductive approach was used in this study. An inductive approach is applied by extracting themes from the raw data as opposed to using a predetermined coding system or theoretically-based categorisation (Boyatzis, 1998; Braun & Clarke, 2006). This approach is aligned with the exploratory nature of the study as not much is known about the research topic. It is particularly useful for gaining new information (Marshall & Rossman, 1999). Allowing data driven themes to emerge increases the probability of describing the

experiences of participants accurately in accordance with their own views (Willig, 2013). It also increases the likelihood that anyone examining the data would come to the same conclusions (Boyatzis, 1998).

Braun and Clarke’s step-by-step guide for doing thematic analysis is a widely used method which most researchers refer to for its clarity and practical use (Willig, 2013; Maguire & Delahunt, 2017). Braun and Clarke (2006) outline six phases of data analysis. The six phases include familiarization with the data, generating the first codes, searching for themes, reviewing themes, defining and naming the themes, and writing the report (Braun & Clarke, 2006).

The familiarisation phase requires a repeated review of transcriptions and audio recordings and making notes of any data that might be seem meaningful. The code generation phase involves identifying both semantic and latent content in the data that may seem interesting to the researcher. It is the production of initial codes. The third phase is a search for themes where the researcher sorts through the initial codes to create possible themes. The fourth phase involves a review and refinement of identified themes. The fifth phase thoroughly solidifies themes and ensures that proper meaning is derived from the data. When the themes have been finalised, the researcher can then compile a report, which describes the results of the data analysis fully.

3.5.5. Reflexivity

As the main research instrument, the researcher has to navigate between managing the research process and being an active participant in the data collection and analysis phases. In qualitative research, the researcher’s personal biases and personal experience are not considered a contaminating factor to the data, but rather

as something that can generate valuable insights (Roberts, 2007). It is important for the researcher to be explicit about any personal beliefs that might influence the researcher's interpretation (Creswell, 2014). Most importantly, it requires a systematic self-reflection of the researcher's role in data production (Roberts, 2007; Schwandt, 2007; Richards, 2009; Roulston, 2010; Patton, 2015). This process is known as reflexivity. Reflexivity is understood in many different ways and is sometimes mistaken for a loose description of the researcher's personal experience (Roulston, 2010; Patton, 2015). Other times it is limited to the researcher's awareness of her or his positioning and how power imbalances may arise as a result of gender, cultural, socio-economic, professional and other differences (Macbeth, 2001). However, there seems to be consensus around the idea that it must provide some methodological credibility (Schwandt, 2007). Schwandt (2007) provided more clarity by adding that reflexivity is not just about documenting something, but also about doing something. What he meant is that the research is not just reporting on some aspect of reality, but is essentially part of that reality as well (Schwandt, 2007). The research is written by a researcher in a context and occurs in with participants in a context (Patton, 2015). Braun and Clarke (2013) explained that the researcher may have an insider or outsider position. The insider shares some characteristics or experiences with the participants while the outsider has no similarities with participants (Braun & Clarke, (2013).

The researcher in this study had more of an insider's position. Through a six-month learnership programme, the researcher was placed in the clinical psychology department of a public health facility. There was a certain level of familiarity with the public health setting which set the foundation for this qualitative inquiry. Her experience formed some assumptions about what a psychologist working in this

setting may experience. These assumptions were further supported by other studies. Based on previous experience, there was an expectation that the public health setting was a challenging place of work. This was based on experiences with resource limitations and their negative impact on service delivery. With such experience, the researcher may have assumed that this would be a stressful work environment. These conclusions were further strengthened by the results of other research. Even though not much is known about the research topic, the limited research reviewed highlighted issues with resource limitations such as lack of office space. The researcher was aware of these assumptions and made a concerted effort not to steer the participants in a particular direction. The interview schedule consisted of open-ended questions. This was line with the exploratory nature of the study. The interview schedule can be found in Appendix E.

3.6. Ethical Considerations

The researcher ensured that all participants were informed about the purpose of the study as well as participant requirements (Willig, 2013). An informed consent letter was sent to each participant was signed by both the participant and researcher to verify participation before data collection. The consent letter is included in Appendix D. The interviews were conducted in a secure and private location to ensure confidentiality. The data were not collected through deceptive means. The researcher was transparent with participants throughout the entire research process (Willig 2013). Participants would be given access to any publications that may stem from the current study. Participants were given the opportunity to withdraw from the study at any point without any consequences (Willig, 2013). All personal details about participants remained confidential and identifying details were removed from

transcripts. Confidentiality was maintained throughout the study. It was the study's imperative to protect all participants from any harm or loss during participation in the study. A free debriefing session through research funding from the Botswana High Commission was offered by a private practitioner, should the participants experience any distress. Arrangements were made with the practitioner. Participants reported that they did not require the services as no distress was experienced.

Since the study was conducted in public health facilities in Botswana, the researcher was given permission by the Botswana Ministry of Health as well as selected hospitals to conduct the study. Permission to conduct the study was granted by the Ministry of Health. Copies of the ethical clearances from the University of Pretoria, The Ministry of Health and the hospital are in Appendix A, Appendix B and Appendix C. The Ministry of Health and hospitals will be provided with a copy of the research report once the study is complete.

3.7. Conclusion

This chapter has explained the methodology in detail and how it was applied to answer the research question. The study was based on the interpretivist paradigm which informed the methodology. The methods of data collection and analysis were qualitative. As a measure of validity, reflexivity was used. Ethical considerations were also discussed. The next chapter will present the analysis and report on the results.

Chapter Four: Results

4.1. Introduction

This chapter provides a report on the results of the study. This study was aimed at meeting the following objectives:

- To explore psychologists' experiences of being integrated into public health facilities;
- To explore how psychologists within public health facilities experience work-related challenges; and
- To explore experiences of job satisfaction and support.

The chapter further explains the process of data analysis by focusing specifically on thematic analysis. Data were collected through three semi-structured interviews and analysed through thematic analysis. Through purposive sampling three clinical psychologists were interviewed for an inquiry about their experiences in public health settings. The findings and analysis are presented with extracts from the interviews to demonstrate the main themes.

In order to meet the research objectives, the data were analysed using a thematic analysis approach. Thematic analysis is a flexible method that was appropriately aligned with the explorative nature of this study. As a method of analysis, thematic analysis is designed to extract themes or patterns from the data (Braun & Clarke, 2006). This was done through an inductive analysis which followed a data-driven approach. This means that there were no predetermined codes or themes (Tsirikos, 2012). The analysis was a six-stage process that involved a

repeated review of the data to generate relevant themes (Braun & Clarke, 2006). These themes were selected based on their ability to create a meaningful representation of the data (Braun & Clarke, 2013). The analysis followed Braun and Clarke's (2006) six-phases of thematic analysis as mentioned in the previous chapter in section 3.5.4. The six-stage process of analysis was implemented once the interviews were transcribed. All the components involved in this process are addressed.

4.2. Data Analysis

Once the transcripts were complete, the researcher revisited both the transcripts and recordings, noting down important points on the electronic versions of the transcripts. This first stage of the process was a familiarisation with the data (Braun & Clarke, 2006). Once this stage was complete initial codes were assigned to describe what was said in the interviews. This type of coding is called complete coding and is distinguished from selective coding (Braun & Clarke, 2013). Complete coding is data-driven whilst selective coding is theory-driven (Braun & Clarke, 2013). Complete coding involves a systematic appraisal of each data item to identify any content that might be relevant to the research question (Braun & Clarke, 2013). A code is a descriptive label that is given to a relevant data extract (Braun & Clarke, 2013). The extract can be coded in several different ways as long as it captures the essence of what was said (Braun & Clarke, 2013). The coding has to be broad and all-inclusive of anything that might be relevant (Braun & Clarke, 2013).

Relevant data extracts were cut and pasted onto a word document. In the word document, the extracts were placed on a table and assigned to a code. The table was divided into three sections with the following labels: initial codes, data

sample and location of data extract. A full version of the coding table can be found in Appendix F. The same process was repeated for all three transcripts. The coding involved continuous reading and re-reading of the data. A significant amount of coded data were obtained during this initial coding phase. This coded data revealed some interesting content about participants' experiences that could later be used to provide a detailed analysis. Once this stage was complete, a search for themes began. This was an active examination of the codes, looking specifically for consistencies and patterns within the data. These patterns were combined to create themes. The themes can be descriptive of behaviour, culture, explanatory statements or narratives (Saldaña, 2009). A combination of these descriptions was found in their similarities. At this stage of analysis any consistencies found among the codes could be used to form subthemes or main themes (Braun & Clarke, 2006). This stage of the analysis was concluded with a set of possible main themes and subthemes.

In the next phase themes were reviewed. The themes were reviewed and refined. Each of the combined coded extracts was reviewed to assess its compatibility with the theme. A few coded extracts were reshuffled whilst some were further collated to refine the themes and subthemes. Both themes, subthemes and codes were reviewed further to ensure that they corresponded with the entire dataset (Braun & Clarke, 2006). After several cycles of review, the refined themes were deemed to be in appropriate correspondence with the dataset.

Once the final reviews were made, the analysis moved on to the fifth stage, the final stage in which themes are analysed, defined and refined (Braun & Clarke, 2006). A thorough understanding of themes was required so that they might be

appropriately defined (Braun & Clarke, 2006). Each theme needed to reflect the core meaning of the data as well as provide some answers to the research questions (Braun & Clarke, 2006). Larger themes were broken down into subthemes. At the end of the stage, a collection of well-defined main themes and subthemes was obtained from the analysis.

4.3. Results of study

Through the complete coding system 133 codes were assigned. These codes were further consolidated to form the following sixteen themes:

1) Formal recruitment by the government through the Ministry of Health;

2) Professional role obligations;

3) Upholding a high standard of care for patients;

4) Psychotherapy

5) Internal and external barriers to treatment ;

6) Resource limitations;

7) Heavy caseload;

8) Foreign psychologists;

9) Institutional level support structures;

10) Communication gap;

11) Support functions;

12) Employment in the public health setting as a rewarding experience;

13) Experience of the regulating body;

14) Establishing a new department;

15) The role of psychology; and

16) Creating an atmosphere for learning and mentorship.

Some subthemes emerged through the continuous refinement of themes. This was done to demonstrate the diverse array of concepts. The themes and subthemes are now addressed along with extracts from interviews.

4.3.1. Formal recruitment by the government through the Ministry of Health

This theme was of particular relevance because all three participants were recruited into the public health facility through the Ministry of Health. The two male clinical psychologists were recruited through a government initiative to employ clinical psychologists and other health professionals from Bangladesh. The female clinical psychologist received a job offer from the Ministry of Health and was posted in a public health facility. She was recruited in Botswana whilst the other were recruited from Bangladesh. This answers the question about how the participants began working in a public health facility. One male respondent (R1) had actually worked in three public health facilities within nine years of public service. The female respondent (R2) had worked at two public health facilities for her whole tenure. The other male respondent (R3) had worked at one public health facility for his whole tenure. Before his recruitment to Botswana, this respondent had not worked in a public health facility. This was an unfamiliar environment for him.

A team went to Bangladesh from Botswana actually before that, we had seen some adverts from the newspapers that Botswana government wants to employ some psychologists. (R1)

I got a job offer with the Ministry of Health and [was] posted to a town four hundred kilometres [away]. (R2).

I applied to… Actually there was a circular of the recruitment in Bangladesh then I applied for this job. They went to recruit us, I went for the exam, I passed the exam and then I was recruited. (R3)

4.3.2. Professional role obligations

This theme captured the work role responsibilities that each of the respondents had on a daily basis. The respondents reported that the main job description was to provide psychological treatment. This treatment was referred to as psychotherapy or counselling. This treatment was administered to both individuals and groups. This professional role also required respondents to participate in other activities as hospital staff members. Respondents were involved in hospital committees, performance management initiatives, meeting accreditation requirements, conducting wellness programmes, conducting educational programmes as part of mental health awareness and prevention. The other responsibilities were later categorised as support functions for psychotherapeutic work. These other functions will be explored further.

Yeah, main thing (inaudible) the description is not really curative [but] to manage the psychological problem(s) at the hospital level. This is my job description. (R3)

Basically it's one to one counselling or the group counselling that we do. (R1)

Other duties that we do as part of the hospital staff for example, we are also engaged in [the] hospital quality improvement committee. (R1)

4.3.3. Upholding a high standard of patient care

Respondents articulated a strong intention and commitment to providing quality services. This theme was related mainly to the respondents' efforts in administering effective psychological treatment. According to R1, quality service was determined by the patient's satisfaction. This respondent emphasised a need to consider various factors when providing quality therapy such as reducing the waiting time, tailoring treatment to the patient's needs and considering the patient's culture. R2 held an unwavering position about the personal value of her profession. She reported a high regard for her profession and said that she tried her utmost to provide good quality. R3 acknowledged his department's efforts and diligence in adhering to the Council of Health Service Accreditation of Southern Africa (COHSASA) requirements. He also mentioned that this standard of work was maintained by conducting regular clinical audits. This theme correlated with the theme of psychotherapy as the quality of service was directly linked to therapeutic work. This will be addressed in the psychotherapy theme.

At the end of the day when the patient is satisfied, that's when we can call it a quality psychological therapy. (R1)

I do it beyond the best of my ability. I don't know how to do half-baked cookies. I do not know how to deliberately give subservice to an individual. (R2)

We are doing well in our department. We always get more than 95 percent marks because we try our level best. (R3)

4.3.4. Psychotherapy

Psychotherapy was one of the main professional roles and was thus correlated with many of the other themes. As a consequence, it carried several subthemes with it. The subthemes were:

1) psychological treatment for a wide range of problems;

2) making therapy more effective through family involvement;

3) Psychological support; and

4) demographics of commonly treated patients.

The respondents reported a variety of consultations with the majority of the patients being adults. One respondent reported that approximately 50 percent of his patients were adults over the age of 18 years, whilst 25 percent to 30 percent of his patients were children, children less 10 years old and children aged 12 to 13 years old. Another respondent reported that most of his patients were adult females between the ages of 19 to 25 years old. Patient data were documented on three individual registers, one electronic register and two manual registers which are subject to a monthly documentation audit.

Respondents encountered serious cases such as depression, anxiety, para-suicide, psycho- sexual disorder (PSD), adjustment disorders, sexual assault, relational problems with family or partner, and social problems. For some of the child cases, attention deficit hyperactivity disorder (ADHD), learning difficulties,

conduct disorder, autism and intellectual disabilities were treated. For another respondent, both male and female patients were represented almost equally with approximately 51 percent females and 49 percent males, and very few pre-teen children. The respondent also pointed to the diverse patient population, categorising different socio-economic statuses and different levels of education among the patient population.

> *As in... It's public health! Its open to everybody. You see the whole strata of society. You see the richest of the rich. You see the poorest of the poor, the most educated of the most educated [and] you see the most not yet educated of the most not yet educated.* (R2).

From R2's perspective, the psychological services were tailored to the significant proportion of physiological conditions manifesting psychologically. Thus the services had to provide support for physical ailments. This was based on the fact that the hospital setup mainly consulted for physiological conditions. However, she did note that some psychological conditions manifested physiologically. She also highlighted that some of the cases required psychological support for families coping with cancer patients, for instance, and end-of life counselling for different wards.

> *It had to be tailored because it would otherwise not make sense. This hospital is a referral hospital. [It's a] hospital for physiological disorders so in setting up this department we were cognizant of the fact that the hospital... (inaudible speech) physical ailments and disorders and diseases, so in tailoring the services that we offered, obviously it wouldn't be in the lines of psychiatric disabilities or disorders.* (R2)

It was a very clinical environment where... Did you know that the bulk of your clients are people that are coming in with a physiological problem maybe manifesting psychologically or a psychological problem manifesting physiologically? (R2)

R3 made mention of numerous periodic calls for grief counselling with grieving mothers in the post-natal care ward. Other times crisis intervention measures were implemented for suicidal patients. A one- to two-hour session might be dedicated to stabilise a suicidal patient. R1 and R3 spoke about group counselling services. R3 mentioned that the group therapy had been previously provided for substance abuse, para-suicide, depression and alcohol abuse. In some instances, groups were formed to cater for a collection of patients with a shared diagnosis, or when deemed necessary.

Sometimes we have also group therapy. We actually, not now… When we started, we had some groups on maybe para-suicide patients who tried to commit suicide, depressed patient, we had also group for alcohol abuse and substance abuse and we also have group for that one [but] now we don't have group therapy but like maybe if we have lot of patients together who maybe lost the baby, grief counselling, the same type of condition who also make a group, we also provide group therapy sometimes when it is needed. (R3)

The most utilised therapeutic modality for R1 and R3 was cognitive behavioural therapy (CBT). R2 did not mention anything about a therapeutic modality. In working with a diverse patient population, respondents discussed how the model was sometimes restructured to accommodate patients' contexts. Respondents mentioned that the model was also combined with other models to

benefit the patients. In his interaction with patients, R1 found that some of the CBT terms were difficult for patients. This was why he considered it important to factor in the patient's level of education, culture and general level of understanding.

Reduction to the prescribed number of therapy sessions became another structural adjustment to the model. The requisite number of therapy sessions was twelve. However, most patients attended five to six sessions.

> *As I said you know like providing whatever the service you provide for your customers, especially the health settings, especially for psychological setups where you need to consider your culture, you need to consider the person's understanding. You need to consider the level of education like for example, CBT if you explain cognitive behavioural model to a patient, some patient(s) might not understand how a thought... the predisposing factor precipitating factor, …(inaudible speech) factor... Those are difficult terms.* (R1).

As mentioned above, the maintenance of quality therapeutic services was an important aspect to respondents such that it continually resurfaced among the themes. R3 reported that therapy was made more effective by family involvement. Family involvement was reported to have a significant role on patient recovery. Family was especially involved for child patients below 18 years old.

> *We try our level best. When a patient comes we want to involve their family because family plays a vital role for a patient's recovery or the outcome of the therapy.* (R3)

For R2 comprehensive psychological support was provided with the aid of medical expertise. Whenever there was an unfamiliar medical diagnosis, she would

seek the medical expertise of a doctor to explain the diagnosis in full. Her intention was to provide a well-informed consultation for her patients.

> *When there was an instance of a teenager who had cancer of the bone and had to have a leg amputated, I'd first have to go for a beautiful learning session with the orthopaedic surgeon to explain to me what it is that he is going to do, how he is going to do it, what the disease progression meant and all that such that by the time I go to meet with the client, then I appear intelligent. So in the process I also learnt a lot about physiological disorders. I'm nowhere near being a doctor from the consultations that I had but I am well-informed.* (Respondent 2)

In her experience, the doctors often seemed too pressured to engage in an extensive discussion with patients about their diagnoses. This often led to hurried referrals to the psychologist. As a consequence, patients were left in a state of confusion regarding their health. It was then that the psychologist would provide clarification and education about the condition as well psychological support. This included counselling for the preparation of procedures and preparations for recovery. In R2's opinion, the doctors' rushed responses may have been a result of the large patient load they consulted and the time constraints involved in such consultations.

> *I don't know if it's because of the time constraints that doctors usually have and the large number of patients that they have, but doctors don't often have a lot of time to spend with the client so it would be like, "Ma'am, we are going to have to cut off your breast because it's got cancer". "Huh? Me! How would I...". "Ok, go to the psychology department".*

So when they come, that is when we start talking about what happened initially to the cell, how it grew big and then spread to the other areas because doctors would've told them that it has metastasised and they then say, "The doctor says it has matters..." Ok, but what they mean is less... so it was a lot of psycho-education for the disorders that they had, for the procedures that they had to undertake and then the counselling for preparation, for whatever procedure it was or life after the procedure. (R2)

4.3.5. Internal and external barriers to treatment

This theme refers to the institutional and patient-related factors that may interfere with treatment. There were various factors involved. Language was occasionally found to be a factor for R1 as he did not speak the local language, Setswana. He reported that there was some difficulty in understanding some patients because of the language difficulties. He noted that some patients did not feel comfortable enough to express themselves in English. The respondent outlined the different options available to circumvent the language barrier. For instance, he suggested that before making an appointment, he would screen for any language difficulties. If any were present, he either requested a translator or made an appointment with a Motswana therapist. He also tried to normalise the situation to relieve any language-related apprehension. In his opinion, after nine years, language no longer posed a great challenge.

As I said, I've been working nine years but really I did not feel this is really a big challenge because as I said, in the beginning, the patients are a bit hesitant you know, in that they will be ok with me but always, when I give the

briefing you know, at the beginning of the session I try to normalise that you know just language. (R1)

The premature termination of therapy sessions was found to be a treatment barrier. The respondents were not certain of its causes but could only make some informed assumptions. For R2, it was mostly her female patients who terminated after the initial sessions. It was mostly the males who continued with therapy. The respondent attributed these differences to societal gender roles. A possible reason was that women tended to hold the position of homemakers and were thus unable to attend therapy sessions to take care of their families. Additionally, women were employed in junior positions and could not excuse themselves too often for therapy sessions. At the same time, women's societal positioning allowed them to confide in relatives and friends for psychological support. Another assumption was that one session was enough psychological support to sustain them. Men predominantly assumed leadership positions and were at liberty to control their own time. This meant they could attend sessions without any restrictions. Men were also less likely to seek psychological support from their families. They instead preferred a more confidential formal source of psychological support.

Women would often-times go and discuss with their cousins or friends [about] whatever it is that is going on in their lives and the men would often just not want to talk about it anywhere else. (R2)

In R3's view, most patients terminated therapy in the early stages of recovery and did not come for follow-up sessions. R1 had similar cases and also came to the conclusion that some patients terminated therapy at the first signs of recovery. This was problematic because patients missed the opportunity of having a relapse plan.

Another assumption was that some had limited knowledge of psychological treatment and did not understand the purpose of weekly therapy sessions.

In his previous hospital, R1's department conducted a study to uncover the causes of early termination. They contacted some patients to find out why they left. Some had to travel long distances which was a major deterrent. Due to financial constraints, some patients were unable to attend therapy sessions. Others simply forgot about their appointments. This seemed to be a common occurrence among the elderly patients. As R1 said, the situation improved once they began issuing reminders to elderly patients.

> *Those are the things that came [up], that it was the distance, the finance or sometimes they forgot their review dates. These are the few things that came out actually.* (R1)

The institutional barriers were mainly associated with the resource limitations. Two main resource limitations were found, namely, the shortage of psychologists and shortage of space. Both resource limitations restricted the number of patients that could be seen on a daily basis. They both interrupted the flow of weekly therapy sessions. This was also reported to contribute to the long waiting period for appointments. In other ways, it limited the level of psychological intervention. For instance, with no child psychologist available, the respondent could only intervene at a rudimentary level.

> *We also do not have equipment for play therapy, so sometimes we just end up just giving some psycho-education to the parent and just see if it works you know, just those [few] are the challenges we have.* (R1)

4.3.6. Resource limitations

As mentioned above, the resource limitations primarily consisted of shortages in space and the shortage of psychologists. According R1, the department had two consultation rooms to be shared between four people. As a result, only two consultations at a time were possible. As a strategy to manage these constraints, two consultations were held in the department and two in the hospital wards. Even with these space constraints, respondents were still able to attend to emergency cases. Both R1 and R3, were quite serious about their efforts to prioritise emergency cases.

> *That we give priority. We see them within [a] full 24 hours especially para-suicide or sexual assault cases.* (R1)

> *What we do by giving the priority which is the first priority which patient needs more urgent attention from us or urgent therapy we give the priority, we prioritise then we manage that way* (R3)

All three respondents had between two and three psychologists within the department. As a consequence, when one colleague went on leave, managing the caseload became difficult, as R3 said.

This theme shares a link with the theme on caseloads, and this because the caseload is directly managed by the number of available psychologists. R1 expressed a need for specialised expertise and facilities for children.

4.3.7. Heavy caseload

This theme referred to all the references made about the workload and constant inflow of patients. R2 reported that the department was always busy and that they received referrals from various departments in the hospital. R1 also confirmed that his department consulted a large number of patients and remained fully booked. R3 said the workload was high and that more psychologists were needed. R3 also shared his perspective on the proliferation on psychological problems. He believed that most psychological problems were due to the social changes brought forth by urbanisation and modernisation. For instance, he attributed the speech problems in children to changes in family dynamics. He explained that in earlier years the extended family was always there for psychological support, but now people lived in nuclear families where both parents worked. This type of family make-up left many isolated and children with no-one to talk to at home which led to speech problems. In addition, modernisation and urbanisation have contributed to the rise in unemployment. The lack of employment has predisposed some to psychological problems such as depression.

> *It was not a sleeping department. It was a busy department. I guess that speaks to what the response was like. We would get referrals from every department in the hospital, from the outpatients department, from surgery, from the theatre room... We'd get referrals from the pharmacy, we'd get referrals from other outlined professionals - the physiotherapists, dieticians and occupational therapists, the speech and audio specialists.* (R2)

> *Yes, I'd say, because we deal with a lot of patients. Why am I saying that? Because our booking(s) are... Maybe if you come now, two (2) days [which*

will be the] 19th [of June], maybe it'll be a month later that we can really give you a date unless it's an emergency. (R1)

4.3.8. Foreign psychologists

This theme focused mainly on the fact a number of the clinical psychologists employed in the public health settings were foreign psychologists. R3 mentioned that there were eight foreign clinical psychologists in a number of public health facilities. This pointed to an initiative to bolster psychological services by employing foreign psychologists.

4.3.9. Institutional level support structures

'Institutional level support structures' refers to the support that was received by the respondents within their place of work. The respondents described a supportive environment. Most colleagues were willing to assist and provide support. R3 mentioned that the hospital management was also supportive. He described an effective multi-disciplinary team. He said that the patients were benefiting directly from the multi-disciplinary approach. For instance, a group of health professionals such social workers, occupational therapists, psychologists, dieticians, nurses, physiotherapists, medical officers and pharmacists all met weekly to discuss difficult patients and how they can best be assisted. He mentioned that this approach gave patients access to different services and they could have their medical, psychological and social needs met in one place. R2 considered the department as a source of support. She also regarded the willingness and openness of medical staff to assist as valued sources of support.

Because I'm not a medical personl, when there was a disorder that I didn't understand, the colleagues in the medical fraternity were always available to explain. (R2)

We have an effective team... (inaudible) every Thursday at half past eight we meet all the professionals like psychologists, occupational therapists, physiotherapists, social workers, dieticians, nurses then medical officers then physicians [and] pharmacist, all of us we meet then there will be a difficult patient which needs all types of services most of the services then he needs or she needs then we'll go with the patient and we'll also discuss about the patient. (R3)

4.3.10. Communication gap

This referred to the communication within the abovementioned support structures. Although there was an effective support structure in place, it did have some drawbacks. This mainly related to communication errors within the referral system. This involved some issues with early discharges from the hospital and incongruous referrals. R1 was concerned about how some clinicians would discharge patients without first consulting with the psychology department. Once patients were physically stable, clinicians would erroneously overlook the emotionally stability of patients. Early discharges led to premature termination of therapeutic treatment. This might have been due to the restricted understanding of psychotherapeutic interventions, as R1 said. R2 received referrals that were inappropriate for therapeutic intervention. This was frustrating and confusing for the patient who was in constant rotation between referrals. R2 pointed that this also caused some frustrations amongst professionals.

…some challenges in terms of when you want to discharge the patient, there may be some do not understand the psychological therapy and other parts like I would say they would just discharge the patient maybe without informing you, maybe the patient wants to go home so they will just discharge or sometimes they would just refer to you say like 'discharge via psychology'. (R1)

"But Mrs M. We brought it to you because you are the psychologist. You can get into the brain." Really, it's frustrating on the sides of both the colleagues, myself and the referring professional. (R2)

4.3.11. Support functions

This theme covered all other duties performed outside the therapeutic function. These included in-service lectures, patient documentation, attending workshops, conducting outreach programmes in prisons and other government institutions, developing treatment guidelines, continuous professional development, infection control audits, case conferences and clinical supervision. There were two types of in-service lectures, the departmental and interdepartmental in-service lectures. The departmental in-service lecture involved discussions about the management of different psychological disorders such as depression, schizophrenia, stress and other disorders. The interdepartmental in-service lecture provided a platform for different health professions to discuss a variety of issues from health issues to financial issues to treatment issues.

The continuous professional development aspect did not seem have formalised training. However, it was supplemented with regular meetings with other psychologists, peer consultation and clinical supervision. This was quite helpful in

that other psychologists were easily accessible for discussions about diagnostic dilemmas. R3 did mention that professional growth was limited.

> *There's risk management issues, infection control issues and then there's case conferencing, there's supervision then all these things you know.* (R1)

> *What we do maybe other psychologists are there when we meet also informally because we know other psychologists especially we're from the same country we'll be discussing about our issues and then if we feel that we need more supervision through phone also as you know that now we have access we have WhatsApp, we have email, we have Skype, we can also contact each other and seek help for the patient, how we can give better service to the patient for clinical supervision.* (R3)

4.3.12. Employment in the public health setting as a rewarding experience

All three respondents valued the experience of working in a public health facility. Respondents perceived it as an edifying professional experience. Working with a diverse patient population enhanced their professional knowledge of a wide spectrum of disorders. R2 was especially grateful for this knowledge because it set the foundation for success in private practice. In addition to the professional development, R2 also recognised the personal development attained from such an experience. She noted that this experience made her more open-minded and broadened her perspective of psychological disorders.

R1 said he was happy with public service and that he accepted the challenges that came along with public service.

For R3 patient recovery was source of motivation. It was gratifying to see patients move from a state of distress to one of hope. R3 appreciated the financial stability of public service.

> *It was a fulfilling learning experience because I know that had I plunged into private practice, I would've got a different crop of clients, of a different mind-set where as in the public health sector I got the whole spectrum of characters, of anything that you can expect in a human being. It really was open. You could get anything of clients and that has helped me personally [and] professionally in that, it has made me a very open-minded person whose vision is quite broad and not specific to trying to specialise if I may say, in more disorders only because that is what I see only. I've been able to deal with DSM 4 from page 46 to page 567.* (R2)

> *Someone is now hopeful, doesn't have any suicidal thoughts that means you are saving life not only one life but you are saving also the family members because if someone loses their family member they'll be also shocked and hurt so how will you feel?* (R3)

4.3.13. Experience of the regulating body

The three respondents were content with the policies and regulations of the regulating body. R1 confirmed that there were no contradictions between practice and the mental health policies. Respondents shared the view that good practice was governed by adhering to ethical principles.

> *You know, if you know your governing ethics of your profession, chances are that you are not going to contravene anything.* (R2)

No, I think there are no issues really. There are no conflicting issues. We follow the health policy of the Botswana government then we [also] have ministry policies and procedures related to psychology specifically. We follow them. (R1)

4.3.14. Establishing a new department

R1 and R2 both spoke about establishing a new department. R2 recalled that they had to buy furniture and other materials and introduce themselves to colleagues and patients. At the time, she was a new graduate with no previous experience of running a department. She was given a senior position and had to map out a direction for a department that had been dormant for six years. R1 explained that it was not just about establishing a new department, it was also about setting the foundation for psychology in Botswana. When he arrived, a clinical psychology department did not exist.

There was no clinical psychology department there so I had to establish the department. There were two psychologi... I would not say they were psychologists [but] there were two degree holders who did psychology. They were actually working under [the] social work department because there was no psychology [department] so when I came to the regional hospital, they joined with me and together, [the] three of us established that department. (R1)

So in coming to the referral hospital in December of 2004, it was to establish a department so [that meant] everything that goes into establishing a department from making your colleagues know of your existence [and to] know of your services, to making clients or patients know of your existence

where in the mornings, as patients are queuing up to see doctors, we would have three and a half minute talks to them to say [that] there's this department that serves people in this way. It meant starting from the very basics of being allocated an office, finding furniture for that office, finding stationary, finding cleaning material [and] everything [else]. (R2)

4.3.15. The role of psychology

As R1 had stated in the previous theme, he and other colleagues set the foundation for psychology in Botswana. As he recalled, this eventually led to the development of accreditation processes as well as policies and procedures. In retrospect, respondents valued the impact of their contribution. The establishment of psychological services made the management of many psychological problems possible, which was a substantial contribution to not just the institutions but the country at large. R1 acknowledged this contribution by noting that they were receiving plenty of referrals as well self-referrals, which meant that people had begun to see the value of psychological treatment. R3 strongly emphasised a need for the psychology association to take charge of making concrete developments in the profession of psychology. He believed that the association had a duty to promote psychology and to tackle all the professional challenges.

It did for Botswana. Something that had lacked for six years was it six... years... 98 99...(counting) Seven years, there about. Many physiological disorders become manageable when you have insight, when you have an understanding of what is going on and when you do not stress about it. Many [of the] clients that were referred to us with whatever physiological conditions, their outcomes were much better than those who were not referred. (R2)

> *We could say [that] we have developed [and] started the department there and it continued and we have done some education to the doctors and we've developed some [of] those recorded policies. As I said, we went to the outreach visits, we went to the public, to the Kgotla meetings [and] to the schools and told people about our profession so I think I would say that is how actually we have started psychology in Botswana.* (R1)

4.3.16. Creating an atmosphere for learning and mentorship

All the respondents had space for intern psychologists in their respective departments. R3 was particularly invested in creating a platform for learnership and growth. His department received numerous interns from the Department of National Internship and Services. The department provided training and career planning for the interns. Students from various institutions enrolled for the programme. All were completing their studies in either counselling or psychology. As part of his recommendations, R3, wanted to encourage such students to further their studies in psychology and for other clinical psychology departments to encourage them.

> *Another thing I want to share with you is that in this department, especially in our department in this hospital, we also train students maybe who did psychology or who did counselling they can come for six weeks to maybe three months they can come and they also do their attachment here. I encourage them to come here and I train them and we also have students.* (R3)

4.4. A theoretical understanding of results

As the data has demonstrated, the derived themes fall within a particular contextual frame. Put together these themes depict social, institutional and environmental aspects within the ecological systems theory. The theoretical premise is based on the interconnectedness and mutual interchange of people and their environments. Some theoretical inferences can be made about what the themes say collectively. At the macrosystem level, which relates to larger organisational structures, cultures, values and traditions, there is a palpable systemic influence from the Ministry of Health. Through the ministry, psychologists were recruited into public health facilities. This was a country-wide initiative that pervaded through the entire health system. Governmental structures determined the work roles and functions of psychologists whilst they were and are employed by the health system. The themes have demonstrated this very pattern, by showing that psychologists responded to the environment accordingly, by performing professional duties such as the treatment of psychological conditions.

Themes such as a heavy caseload, internal and external barriers to treatment and experience with the regulating body are directly and indirectly affected by macrosystem structures. For instance, the respondents explained that one of the major contributions to a heavy caseload was the scarcity of psychologists. Regarding this particular issue, one respondent pointed to a deficit in the training of psychologists. The lack of trained psychologists translated into an structural treatment barrier. This means that there was a limit to the number of patients who could be treated because of the lack of psychologists. This possibly highlights a dependency upon the governmental structures to train more psychologists. In

another example, the respondents' experience with the regulating body is an illustration of an individual's relationship with a macrosystem structure.

As far as traditions and cultures in the macrosystem are concerned, the proliferation of mental health conditions was attributed to economic and societal shifts. These shifts had a direct impact on family dynamics which predisposed many to psychological conditions, according to R3's observations.

From the perspective of the chronosystem, it is evident that many changes in the health system have occurred over time. The integration of psychologists into the health system was a significant transition. According to the respondents, numerous developments were made to formalise and regulate psychology as a profession in Botswana. It seems that these developments made psychology a much welcomed addition to public health facilities. This pertains to the theme on the role of psychology in which respondents proudly acknowledge psychology's contribution to the health system.

The exosystem refers specifically to the hospital environment and its influence on the respondents. Themes relating to support structures and functions, resource limitations and establishing a new department all fall within the exosystem. In the hospital, support was offered through various means such as collegial support, multidisciplinary team effort and management support. Additional forms of support included in-service lectures, supervision and workshops. As part of the hospital, the respondents were required to participate in programmes such as infection control audits, quality improvement and performance management. The resource limitations seemed to be a constant part of the hospital environment. However, respondents were able to adapt and function in spite of them. In terms of establishing a new

department, respondents were responsible for forging relationships with hospital staff and patients in order to be establish themselves as members of the exosystem.

The mesosystem is the level at which interactions between the respondents and hospital staff took place. The communication gap and institutional level support are themes that best illustrate the interpersonal interactions between the respondents and colleagues. The mesosystem also refers to a connection between microsystems as patients move through different levels of care. The results have shown a communication gap between microsystems which led to incoherent referrals. On the other hand, the results also showed that the respondents felt supported despite the communication breakdown.

The microsystem is represented by a small immediate environment in which most interactions occur. In this case, this would be in the clinical psychology department where all three respondents carry out their duties and interact with patients. The respondents interact with patients through direct treatment and with each other as colleagues.

In summary, it is clear that the results have revealed that each level of the ecosystem is represented, possibly showing that the ecological systems theory was meaningfully applied in the study. Even though the levels are separate, they do not operate in isolation. It is an intertwined and interlinked system that operates much the same way as a society would with varying hierarchies of social structures. Further theoretical interpretation of the results will be provided in the next chapter.

4.5. Conclusion

This chapter presented and reported on the results of the study. An outline of the data analysis was presented. Data were analysed through thematic analysis. This analysis produced 133 codes and 16 themes. All these themes answered the research questions and provided a detailed account of the experiences. In summary, the results revealed that respondents had a rewarding experience with a variety of factors contributing to that experience. The respondents offered a detailed account with advantages and disadvantages. The chapter also provided a report on the theoretical positioning of results which showed how the ecological systems theory was applied to the results. The results showed that various themes were located within each of the levels of the ecological systems theory. The next chapter will present a discussion of these results and the research conclusions.

Chapter Five: Discussion

5.1. Introduction

This chapter presents a discussion on the results and provides an interpretation of the results. It discusses the extent to which the aims and objectives of the study have been met. It determines the degree to which the research questions have been answered. The results are examined in the context of previous research and the theoretical framework. This chapter integrates the study in its entirety looking specifically at the relevance and significance of the study. Finally, it presents recommendations and conclusions.

5.2. Review of the study

The current study used an exploratory qualitative design. The study followed an exploratory design to provide a descriptive account of a newly researched topic. The methodological design was informed by an interpretivist paradigm. This paradigm was aligned with the qualitative nature of the study and allowed for an exploration of the participants' experiences. The main objective was to provide a report on the work-related experiences of psychologists in public health facilities in Botswana. Three semi-structured interviews were conducted with three clinical psychologists from Botswana who were selected through purposive sampling. The interviews were conducted, recorded, transcribed and analysed in English. The thematic analysis method was used to analyse the data. Themes were extracted through an inductive approach. Out of the analysis, 133 codes and 16 themes emerged. This investigation was undertaken to meet the following research objectives:

- To explore psychologists' experiences of their integration into public health facilities;
- To explore how psychologists within public health facilities experience work-related challenges; and
- To explore psychologists' experiences of job satisfaction and support.

The research study was theoretically framed under the ecological systems theory and supported by reported research on the various factors involved in mental health services. Research conclusions are limited to the scope of this study which mainly focused on the experiences of psychologists in Botswana. The discussion begins by reviewing the research results.

5.3. Summary of results

A significant amount of data was obtained. 133 codes and 16 themes were identified from the data analysis process. These themes are discussed in relation to previous research and the theoretical framework. The theoretical framework was based on the assumption that contextual factors have an influence on one's behaviour. These contextual factors are centred around a multi-layered ecosystem. The layers consist of the microsystem, mesosystem, exosystem, macrosystem and chronosystem (Bronfenbrenner, 1994). The microsystem is the immediate environment, whilst the mesosystem is a link between different environments. The exosystem encompasses a larger social system whilst the macrosystem is a network of larger social systems (Bronfenbrenner, 1994). For example, this is inclusive of social policies and legislation. The chronosystem involves the major changes that have occurred over time (Bronfenbrenner, 1994).

5.3.1. Formal recruitment by the government through the Ministry of Health

Each of the participants was formally recruited by the government of Botswana through the Ministry of Health. The government of Botswana is responsible for a large percentage of health care provision and as such is a primary employer for health care professionals (Nkomazana et al., 2014). What the respondents said about their recruitment into the public health facilities greatly corroborated previous research findings. No documentation on the recruitment of clinical psychologists from Bangladesh was found when the research was conducted. However, it is highly possible that such documentation exists and could be found upon further investigation. Theoretically not much can be said about respondents' appointment into the public facility except that their appointment was a result of structural decisions made in the macrosystem by a larger social structure. Looking back at previous research, such an initiative would be evidence of a more inclusive mental health policy, a policy that has integrated mental health services into the broader health care system. As demonstrated by previous research, Botswana did have such a policy (MOH, 2003).

5.3.2. Professional role obligations

The respondents outlined a range of different professional duties in the public health setting. The core professional responsibility for each of the respondents was to provide psychological treatment. This core responsibility was commonly referred to as psychotherapy or counselling. As members of a medical institution, respondents were required to participate in activities such as performance management initiatives, quality improvement committees, maintaining accreditation requirements, conducting mental health awareness and prevention programmes.

Previous research has indicated that clinical psychologists are known to perform such duties in health care settings. McDaniel and DeGruy (2014) indicated that psychologists can assume several different positions within a health care setting. An example of this would be the facilitation of quality improvement measures. Under Bronfenbrenner's (1994) theory, this would be a direct interaction with the immediate environment.

5.3.3. Upholding a high standard of care

As the results have revealed, the research respondents demonstrated a high level of commitment to effective service delivery. Each respondent shared a different perspective on the importance of prioritising patient care. Firstly, the definition of effective treatment was based on the level of patient satisfaction. Secondly, a good measure of quality was determined by a successful evaluation from the accreditation body. Lastly, it was about displaying a high level of respect for the profession and making a concerted effort to provide good quality services. Swarts (2013) shared the same point of view, stating that maintaining a high standard of care was an essential component for psychological treatment, especially for underserved communities. Her argument was that services in public health facilities were being rendered mainly to a disadvantaged population. Providing substandard services would add to their already existing distress (Swarts, 2013). This thought process goes against the expected theoretical assumption. Based on the ecological theory, it would be expected that the respondents would succumb to the environmental influences, the environmental influences being the resource limitations. However, respondents chose to go against the dictates of resource limitations to exhibit a high standard of professionalism.

5.3.4. Psychotherapy

As the one of the main professional responsibilities, psychotherapy was linked to many themes. It comprised of four subthemes: 1) psychological treatment for a wide range of problems; 2) making therapy effective through family involvement; 3) psychological support; and 4) demographics of commonly treated patients. Respondents consulted on a wide range of psychological problems with varying proportions of adult and child patients. Female patients were in the majority. A variety of serious cases were encountered from para-suicides to sexual assault and depression. The patient population was diverse, covering different levels of socio-economic status and education. Psychological support was offered to terminally ill patients and their families, and grieving mothers. The services were specifically tailored to the medical setting with the aim of providing psychological treatment for physiological conditions. This was in line with the role of a clinical psychologist working in a health setting such as this (McDaniel & de Gruy, 2014). In some instances the clinical psychologist was required to be an intermediary for medical personnel and patients (McDaniel & DeGruy, 2014). This was true for R2 who had to liaise with both doctors and patients in preparation for medical procedures and counselling for serious medical conditions. The psychologist's interaction with patients and fellow psychologists in the department would be an example of the microsystem, whilst interaction with the doctors and colleagues outside the department would be an example of the mesosystem.

Respondents mostly followed a CBT approach combined with other therapeutic modalities when necessary for the best treatment outcomes. Not much previous research on the efficacy of treatment modalities in primary health care was

found. This could be an area for further research. Another contributor to better treatment outcomes was family involvement.

The mental health policy of Botswana (MOH, 2003) outlined similar psychological problems to a certain degree. However, it is important to note that it was published in 2003. It is possible that some significant changes may have of occurred since its publication. Its primary objectives remained relevant to this study. For instance, one of the main objectives was to prioritise family involvement by supporting and educating caregivers. R3 placed great emphasis on this subject. Family involvement is included in the in the public service report on the work roles of clinical psychologists (DPSM, 2013). This could be an indication of how significant family involvement is to treatment outcomes.

5.3.5. Internal and external barriers to treatment

Some internal and external barriers to treatment were identified by all respondents. Language was found to be a communication barrier in treatment. This was due to the cultural disparities between the foreign clinical psychologists and patients. Respondents made efforts to remedy the situation so that patients were not denied treatment. For this reason, language was considered a minor barrier to treatment.

The premature termination of therapy sessions proved to be an unavoidable treatment interference. Respondents recounted several reasons from a professionally informed point of view. Social dynamics seemed to play a role in treatment adherence. For example, the gender disparities between men and women determined who could attend therapy and for how long. The discontinuation of treatment was also attributed to early symptom relief. Early discontinuation

circumvented the implementation of a thorough relapse prevention plan. According to one respondent, this was a possible demonstration of patients' limited understanding of psychological treatment. Some patients tended to forget their appointments. This was more prevalent among elderly patients. However the situation improved once appointment reminders were sent out to patients.

Patient-related circumstances involved issues with distance and financial constraints. This might point to a problem with the access to services, possibly highlighting a discrepancy with the implementation of the mental health policy. The mental health policy aimed to improve access to mental health services (MOH, 2003). Such cases signify that improvements still need to be made. This point was strongly emphasised in the literature review, demonstrating that the situation was not unique to Botswana (Saxena, Thornicroft, Knapp & Whiteford, 2007; Swarts, 2013; Daar et al., 2014; Monteiro, 2015).

Institutionally-based barriers were characterised by shortages of psychologists and of space. These shortages were the cause of interruptions and delays in treatment. This is also a commonplace developmental challenge as described by Kakuma, et al. (2011), Seitio-Kgokgwe et al. (2014), Nkomazana, Peersman, Willcox, Mash & Phaladze (2014), Seitio-Kgokgwe et al. (2016), and Mugisha et al. (2017). According to the ecological systems theory, these structural challenges are bound to have an impact on the system. Problems can be identified at various levels of the ecosystem. This discussion continues in the next theme.

5.3.6. Resource limitations

As mentioned above, the resource limitations have an effect on treatment interventions and this is further transmitted to patients and the institution as a whole.

From a systemic point of view, this relates back to policy implementation and the health system at large. The mental health policy stipulated that mental health providers at all cadres must be trained. Not enough mental health professionals were being trained. This was mentioned by one of the respondents and has been supported by previous research (Kakuma et al., 2011; Szabo, 2013). This also demonstrated that the situation has continued for many years. In addition, the shortage of psychologists is ubiquitous to most LMICs (WHO, 2013; Smith et al., 2017).

Previous research has shown a general deficit of health professionals in Botswana and many other countries (Nkomazana, Peersman, Willcox, Mash & Phaladze, 2014; Seitio- Kgokgwe et al., 2016). This is due to various problems within the health systems. For most LMICs the problem relates to funding and resource management (Awenva et al., 2010; Smith et al., 2017). The shortage of space is a common phenomenon in most public health settings and also points to inadequate funding and resource management (Szabo, 2013; Padfield, 2015). In essence, governmental issues trickle down to institutions and even further to practitioners and patients. This would be a clear illustration of the interconnectedness of the levels of the ecological system. Major decisions are made in the macrosystem (governmental policies and legislation) which affects the exosystem (public facilities), the mesosystem (interaction between departments), and eventually the microsystem (clinical psychology department). These challenges relate to issues in mental health policy implementation.

Applied to the system in Botswana, the policy specifies that mental health professionals must be trained. The fact that not enough mental health professionals

are being trained points to a problem with the implementation of the mental health policy. A possible explanation for this is that there is a low prioritisation of mental health services such that most health systems allocate only a small percentage of the health budget to mental health services (Saxena et al., 2007; Kigozi & Ssebunnya, 2009; Jenkins et al., 2010; Petersen et al., 2011; Hanlon et al., 2016; Smith et al., 2017; Mugisha et al., 2017). Botswana allocates one percent of the health budget to mental health services and is possibly unable to train more clinical psychologists for this reason.

5.3.7. Heavy caseload

The resource limitations ultimately have an impact on the caseload. With few psychologists to manage the patient load, it is inevitable that most clinical psychology departments would be overwhelmed. The psychologist to patient ratio in Botswana was approximately 0.3 psychologists per 100 000 people a few years ago (Pheko et al., 2013). More recent statistics were not found at the time of investigation.

One respondent made an important observation on the prevalence of mental health conditions. The ripple effects of developments in modernisation and urbanisation have eroded the social constitution. This had been acknowledged previously in the mental health policy (MOH, 2003). A disintegration of the extended family, unemployment and social isolation were some of the issues encompassed in the policy (MOH, 2003). This indicates that the respondent’s observations were most probably accurate.

5.3.8. Foreign psychologists

As was mentioned previously, the recruitment of foreign psychologists was not supported by any research or documentation at the time of investigation. Respondents reported that several other professionals were also recruited from Bangladesh. Possibly an initiative to augment the human resource shortages needed. Further investigation is required.

5.3.9. Institutional level support structures

Respondents evaluated support structures positively. They all reported positive collegial interactions and support from the hospital management. Many studies have had contrasting experiences, mainly indicating unsupportive work environments (Swarts, 2013; Padfield, 2015; De Sousa & Dela Coleta, 2015). One study by Pillay et al. (2012) in South Africa did, however, show that most clinical psychologists felt supported in public health facilities.

5.3.10. Communication gap

Even though respondents reported a workable support structure, there were some hindrances. Substantial communication gaps in the referral system were reported. Frustrations over misdirected referrals and early discharges arose between colleagues. July's (2009) study conducted in Botswana in a public health facility revealed that most health workers made appropriate referrals to psychologists. In contrast, a study by Swarts (2013) showed that, as a psychologist, she received inappropriate referrals. This possibly confirms what is said about the biomedical model within medical institutions (Van Wyk & Naidoo, 2006; Hanlon, et al., 2016). As R1 said, the early discharges might have been due to a prioritisation

of medical conditions over psychosocial ones. This is an illustration of biomedical bias. From a systemic point view, this appears to be a slight break down in the mesosystem.

5.3.11. Support functions

The support functions consisted mainly of administrative duties and other professional obligations such as workshops and in- service training. These functions are considered to be part the psychologist's role in the public health setting (DPSM, 2013). R3 highlighted the fact that professional growth was limited, especially in terms of continuous professional development. Nkomanzana et al. (2014) made reference to challenges with in-service training. These challenges were a result of insufficient funding (Nkomanza et al., 2014).

5.3.12. Employment in the public health setting as a rewarding experience

All respondents' evaluations of the experience in a public health setting were positive. Respondents valued patient care and recovery. It was considered an enhancing professional experience. Pillay et al. (2012) showed that clinical psychologists had a positive experience in the public health setting and were satisfied with the clinical experience. Some studies showed that clinical psychologists were motivated by patient recovery and indicated that effective service delivery was possible in spite of resource limitation (Padfield, 2013; 2015). This was linked to the message that R1 tried to convey, that the advantage of working in a public health setting was the stable salary.

Some studies argued that working conditions were demoralising because of the resource shortages (Szabo, 2013; De Sousa & Dela Coleta, 2015). Others argued that these resource shortfalls led to staff attrition and migration to high-income countries (Szabo, 2013; Monteiro, 2015).

5.3.13. Experience of the regulating body

Respondents were satisfied with the regulating body and had no problems with it. This would be an accurate conclusion to make considering that the objectives of the mental health policy were still relevant to respondents' practice. Respondents believed that good practice was determined by an adherence to psychological ethical principles. Most previous research would counter this view, looking specifically at the shortages in human resources (Monteiro, 2015; Reuter, McGinnis & Reuter, 2016; Mugisha et al., 2017). This would demonstrate a lag in implementation.

Another example highlighted in this study was the lack of professional growth or initiatives to meet the demands of continuous professional development. This was stipulated in the mental health policy (MOH, 2003), but it seems that it has not been put into practice.

5.3.14. Establishing a new department

Respondents had to start from the beginning to establish a new department. This entailed a range of factors from resource allocation to the purchasing of new materials. Respondents had to introduce the profession of psychology to medical officers and patients. This may be a confirmation that psychology is a relatively new profession in Botswana (Plattner & Moagi-Gulubane, 2010; Pheko et al., 2013).

5.3.15. The role of psychology

According to the respondents, the introduction of psychological services in the public health facility made a country-wide contribution. Respondents participated directly in the development of accreditation processes and procedures. A great achievement was that medical officers and patients were making use of psychological services. This was a possible indication that the services had a meaningful impact, according to R1. This very point encapsulates the significance of the current study. It is greatly supported by previous research. The management of psychological conditions is an exceedingly important matter. As previous research has highlighted, mental health conditions have a bearing on an individual's ability to function (WHO, 2013). This point is so important that increasing the access to mental health services is an international commitment by the WHO member states (MOH, 2003; WHO, 2013).

5.3.16. Creating an environment for learning and mentorship

All respondents incorporated a learnership programme into their department. According to R3, interns were encouraged to further their studies in psychology and also received mentorship and career planning. In R3's opinion, this was done to augment the training deficits. Botswana relied on international institutions for the training of psychologists. There was no recent documentation to verify this when the study was conducted.

5.4. A theoretical positioning of the study

As was previously mentioned, the study used the ecological systems theory as a theoretical framework. The semi-structured interview had the main intention of

creating an atmosphere for understanding the context in which the respondents worked. A theoretical application to the results showed that collectively the themes were directly linked with each of the levels in the theory. The entire study follows a similar structure which is why the literature reviewed mental health policies and their impact on service delivery in Botswana and other African countries. This was based on the understanding that major policies fall within the macrosystem which ultimately affects the lower levels. As discussed in chapter 2, various studies in the literature review have shown the way in which mental health policy implementation has affected many areas of practice. The main point of contention amongst the studies was that many countries seem to struggle with prioritising mental health services. The prioritisation is also centred in a belief system that gives precedence to medical conditions over psychological ones. These can be said to be macrosystem issues. One of the recurring themes in the literature and the data was the shortage of resources brought upon by macrosystem processes. This is of course linked to the budgetary constraints which affect the exosystem. Hospitals were restricted in the number of psychologists they can employ and in the physical space they can provide for them. However this did not compromise on the quality of services provided as respondents had clearly stated that they uphold a high standard of care for their patients in spite of the challenges. This was another point which was highlighted in chapter 2 under the section on the experiences of psychologists.

This might indicate a reciprocal relationship in which individuals are responsible for creating a conducive work environment for themselves in the microsystem. This exemplifies how individuals relate with their environment as active agents. For instance, respondents were responsible for developing practice regulations and guidelines which were further taken up to the macrosystem to

become general practice guidelines for psychologists in Botswana. This is evident in the theme of the role of psychology where respondents stated that they actively participated in strengthening the presence of psychology in Botswana.

These efforts became developmental changes in the chronosystem allowing psychology to be recognised with new departments being established in several hospitals around the country. Of course the macrosystem was also responsible for these changes since the MOH first started by recruiting psychologists who would later implement these changes. This further illustrates the reciprocity of the levels in the ecological systems theory.

The respondents described a supportive relationship within the mesosystem showing that fellow health professionals were helpful and accommodating. This relationship was strengthened by the weekly multi-disciplinary meetings that created an environment for professional engagement and expertise exchange. On the whole, it can be said that macrosystem structures govern all other levels but at the same time requires a mutual response from those levels to achieve its main purpose.

5.5. Accountability of the study

In this study reflexivity served as a measure of reliability. Reflexivity is considered to be a reliable tool to guard against the interference of researcher bias (Schwandt, 2007; Creswell, 2014). As mentioned in Chapter Three, the researcher was able to suspend her interpretations during the research process. Researcher bias was monitored through supervision and constant reflection. With a previous history in the public health setting, it was easy for the researcher to identify with

respondents, however this was averted. The interview schedule also served as guide to keep the researcher from going beyond the limits of this study.

5.6. Research conclusions

The research question asked what were the work-related experiences of psychologists in public health facilities in Botswana. There were three objectives to support the research question. It can be concluded that the study was able to meet the research objectives and answer the research question. According to the research results it would appear that the experiences of psychologists in the public health setting were multi-faceted.

As this study has shown, there were different systemic factors that contributed to this work-related experience. It was found that all levels of the system were interlinked, and changes in the macrosystem level structures had a cascading effect on all the other levels. This relates to issues with mental health budget allocations. A small percentage of the health budget is allocated to mental health services and this might be the reason for resource shortages. This seems to contribute to the low numbers of clinical psychologists in the public health setting. The low numbers have created an imbalance of the staff to patient ratio, possibly showing that that the services may have been overstretched. This was also a treatment barrier limiting the number of patients who could be seen at a particular time.

Sixteen themes were identified in the study. The results showed that psychologists were mainly recruited by the government. In an effort to bolster psychological services, foreign psychologists were recruited from Bangladesh. This initiative seems to have been successful to some degree. However there was still a

shortage of psychologists. Recruiting foreign psychologists had its drawbacks, especially because of the cultural disparity. Language difficulties were experienced by the participants. Participants did make an effort to manage these difficulties. Respondents considered this a minor barrier because it caused little interference in treatment.

Respondents were dedicated to providing quality services, even in the face of resource limitations. That may reflect a level of resilience in the participants. Possibly more research could be conducted on this. For instance, the research could focus on the coping mechanisms of psychologists in a resource-limited facility.

Two of the respondents had to establish the clinical psychology department from the beginning. This could possibly mean that psychology was considered a new profession as compared to professions that had previously been there for decades, such as medicine. This could explain the lapses in communication which might have been due to a limited understanding of psychological services.

5.6.1. Objective 1: To explore psychologists' experiences of their integration into public health facilities

In response to the above research question, the results demonstrated that the respondents held a positive perspective on working in a public health facility. Their experience of being integrated into a public health facility seems to have been wholly positive. Respondents were cognizant of psychology's contribution to the health setting. The psychological management of both physiological and psychological conditions was possible because of this integration. However, it seemed that there were some problems in accessing the mental health services for some of the population which was a treatment barrier. This was possibly due to the fact that most

mental health services were located in larger referral hospitals rather than in primary health care clinics. Populations in outer regions were slightly disadvantaged by this.

5.6.2. Objective 2: To explore how psychologists within public health facilities experienced work-related challenges

Work-related challenges presented themselves in the form of communication lapses, treatment barriers, resource limitations, limited professional growth and a heavy caseload. It seemed that the respondents had developed a mature perspective about their working conditions, choosing instead to focus on delivering a higher quality of service.

5.6.3. Objective 3: To explore psychologists' experiences of job satisfaction and support

In terms in of job satisfaction and support, the respondents reported that they were satisfied with their clinical work and even had a sense of accomplishment. They also demonstrated a sense of appreciation for the support structures. The respondents' main recommendation was for more psychologists to be trained and integrated into the public health facility.

5.7. Research Reflections

The main concern was that the interview questions were broad. The participants mentioned that sometimes the questions were difficult to answer. The researcher had to narrow down the questions and provide examples to make it easier for the respondents to understand. At other times the respondents seemed to suggest that there was a repetition of questions by continually repeating certain statements to show that they had answered that question before. This may have

been due to the broad nature of questions. To some extent it was difficult for the researcher to follow the structured questions. In addition, the difficulty may have been related to her previous history in the public health setting. The researcher leaned to towards a certain view of the public health setting and wanted to ask questions that were more related to her previous knowledge. Herewith the researcher acknowledged her own bias. However, this was managed. Before each interview was conducted, the researcher and supervisor engaged in a preparatory discussion to anticipate which questions would lead to a more biased view.

It became clear upon further reflection that the interviews had actually yielded some detailed results. This can be attributed to the recursive nature of the study. The re-reading of transcripts continually revealed new information and new interpretations. It is possible that further reflection on the data may reveal more insights.

5.8. Limitations of the study

The study was limited in scope to focus specifically on the experiences of clinical psychologists in public health facilities. As the paradigm suggests, the experience was based on time, person, place and context, so a similar study may not yield the same results.

The study was limited by the fact that there were very few previous studies on the topic which limited the literature review. Very few studies on the experiences of psychologists could be found and even fewer on their experiences in the public health facilities. Only one study was conducted in Botswana by July (2009). This study was conducted ten years ago. Therefore there was a significant gap in the

literature. There were also no data on the number of psychologists in public health settings when the study was conducted. It is quite possible that these statistics are available at the Ministry of Health. Further inquiry would be required.

Another limitation was that it was difficult to find willing respondents. No participants were recruited from a rural setting because there were no psychologists working in rural areas. There were also only three participants in this study.

In addition, the study was limited in its theoretical application. Possibly a more context-specific theory would have provided a more in-depth explanation of the results.

This study was also limited by the fact that it was an explorative study. This means that it can only be descriptive. Further investigation is required to provide more specific conceptualisations of the research concepts.

Two out of three participants were foreign clinical psychologists. This indicates a reliance on other countries for mental health human resources. Not much is known about the specifications for their recruitment in the public health facility and more investigation is needed. For instance, there was no knowledge about why the government chose the country of Bangladesh for the recruitment of clinical psychologists. There was also no information on how long they were contracted to be in Botswana.

Although many themes were identified, each theme could be expanded. For instance, more information is needed on how the respondents managed the communication gaps. This means some of themes were more of an exhaustive list of activities rather than a detailed account. For example, the theme on supportive

functions provides only a list of duties and does not go into detail about how the participants experienced these support functions.

5.9. Recommendations

It is recommended that further investigation be conducted into psychology in Botswana. Furthermore, as the study revealed that psychology plays an important role in the health system, more studies would be of scientific value.

It also recommended that more studies on the experience of psychologists is needed. The study revealed sixteen themes which might be a sign that further investigation into some of those themes is needed. In addition, there is limited research on experiences of psychologists in public health facilities.

It is also recommended that access to mental health services be increased in other primary care facilities such as clinics in far-to-reach destinations. This would assist with the premature terminating of patients who live on the outskirts of the regional hospitals. In addition, medical personnel in the primary health posts can be trained to deliver brief psychological interventions. Specialised programmes can also be developed to assist with premature termination. Another would be to provide short-term therapy to avoid unfinished treatment interventions.

Only clinical psychologists are recruited into the public health facilities. Other branches of psychology such as counselling psychologists, educational psychologists, research psychologists and industrial psychologists are also trained to work with various psychological issues. Their treatment interventions can also be applied to the psychological management of physiological conditions (Wahass, 2005). Educational psychologists specialise in the treatment of adolescents and

children and would be especially useful for child patients. Incorporating them in to the health system may help to ease the load of cases.

More support needs to be given to the psychology association in Botswana. It has been developing slowly for many years. A lot is required from the association as a regulating body. It will need to contribute to the development of the profession.

In addition, more psychologists need to be trained. A significant number of psychologists are needed to balance the staff to patient ratio. In addition, more psychologists will be needed as the burden of mental health conditions continues to grow.

Psychological tests need to be standardised for the population in Botswana. A variety of tests are required for different types of assessment such as aptitude tests, intelligence quotient (IQ) tests, diagnostic tests and neuropsychological tests. These are but a few examples, however in essence thorough developments are needed in this area.

The professional growth of psychologists should be prioritised in order to keep the profession growing. This would enhance the professional knowledge of psychologists and keep them abreast of the latest developments in treatment. The mental health policy should make improvements to the implementation process. Regular evaluation and monitoring of implementation are required.

5.10. A Reflection

The study allowed for the personal reflection of participants as well as a broader perspective of psychology in Botswana. The research participants were given an opportunity to access the results of the study. The researcher is open to

having a discussion with participants about the results should they require any clarification.

It has to be acknowledged that some major developments have already been made in the profession of psychology. It is believed that with more commitment these developments can expand. The researcher would like to acknowledge and thank all the organisations involved for their cooperation and support. Finally, the researcher would like to express her gratitude to the participants for taking time out of their schedules to be a part of this study. Their contribution to the profession is acknowledged and greatly appreciated. Some great strides have been taken to bring the profession to where it is today.

5.11. A Personal Note

The magnitude and gravity of this study cannot be overstated. It has left a profound impact on me as the researcher and placed a growing desire to make a contribution. As a novice researcher, my understanding of conducting qualitative research was greatly enriched. The research process demanded a more in-depth engagement with the data which made the experience more personal. As the researcher, I came in with a narrow perspective of the profession but now after having this experience, my view has changed. I gained access to the complexities of psychologists' work-related experiences. I appreciate the undeniable steadfastness it took to develop this profession from the ground up. I also appreciate the maturity it took to endure the growing pains of a new profession; overcoming one obstacle after another. I have since developed great respect for psychology in general and for psychology in Botswana. It is my hope that this research will make a difference in some meaningful way.

References

Atieno, O. P. (2009). An analysis of the strengths and limitation of qualitative and quantitative research paradigms. *Problems of Education in the 21st century,13*, 13-18. Retrieved from http://www.scientiasocialis.lt/pec/files/pdf/Atieno_Vol.13.pdf

Atilola, O. (2014). Mental health service utilization in sub-Saharan Africa: is public mental health literacy the problem? Setting the perspectives right. *Global Health Promotion, 23*(2), 30-37. doi: 10.1177/1757975914567179

Awenva, A.D., Read, U.M., Ofori-Attah, A.L., Doku, V. C. K., Akpalu, B., Osei, A.O., Flisher, A.J., & Mental Health and Poverty Project Research Programme Consortium. (2010). From mental health policy development in Ghana to implementation: What are the barriers?. *African Journal of Psychiatry, 13*, 184-191.

Battaglia, M. P. (2011). Purposive sample. In P. J. Lavrakas (Ed.), *Encyclopedia of survey research methods* (pp. 645-647). Retrieved from http://methods.sagepub.com/base/download/ReferenceEntry/encyclopedia-of-survey-research-methods/n419.xml

Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, J.R., Mwanza, J., & MHaPP Research Programme Consortium. (2011). Increasing the priority of mental health in Africa: findings from qualitative research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning 26*, 357–365. doi: 1093/heapol/czq078

Blaikie, N. (2004). Interpretivism. In M. S. Lewis-Beck, A. Bryman & T. Futing Liao (Eds.), *The Sage encyclopedia of social science research methods* (pp. 509-510). Retrieved from http://methods.sagepub.com/base/download/ReferenceEntry/the-sage-encyclopedia-of-social-science-research-methods/n442.xml

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, California: Sage Publications.

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage Publications.

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage Publications.

Bronfenbrenner, U. (1994). Ecological models of human development. In M. Gauvain & M. Cole (Ed.), *International encyclopedia of education* (2nd ed.) (pp. 37-43). Retrieved from http://edfa2402resources.yolasite.com/resources/Ecological%20Models%20of%20Human%20Development.pdf

Burgess, R. A. (2016). Policy, power, stigma and silence: Exploring the complexities of a primary mental health care model in a rural South African setting. *Transcultural Psychiatry*, *53*(6), 719–742. doi: 10.1177/1363461516679056

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research*, 17(10), 1316-1328. doi: 10.1177/1049732307306927

Charlson, F. J., Diminic, S., Lund, C., Degenhardt, L., & Whiteford, H. A. (2014). Mental and substance use disorders in Sub-Saharan Africa: Predictions of epidemiological changes and mental health workforce requirements for the next 40 Years. *Plos One*, *9*(10), 2-11.

Creswell, J. W. (2007). *Qualitative inquiry and research design* (2nd ed.). Thousand Oaks, California: Sage Publications.

Creswell, J. W. (2014). *Research design: Qualitative, Quantitative and mixed methods approaches* (4th ed.). Thousand Oaks, California: Sage Publications.

Daar, A. S., Jacobs, M., Wall, S., Groenewald, S., Eaton, J., Patel, V., dos Santos, P., Kagee, A., Gevers, A., Sunkel, C., Andrews, G., Daniels, I., & Ndetei, D. (2014). Declaration on mental health in Africa: Moving to implementation. *Global Health Action*, *7*(1), 1-4. doi: 10.3402/gha.v7.24589

De Sousa, A. A., & Dela Coleta, M.F. (2015). Professional profile, well-being and job satisfaction among psychologists working in public healthcare services. *Estudos de Psicologia Campinas,32*(2), 249-258. doi: 10.1590/0103-166X2015000200009

Della Porta, D., & Keating, M. (2008). *Approaches and methodologies in the social sciences*. New York, NY: Cambridge University Press.

Directorate of Public Service Management. (2013). Botswana public service competency based career path for Ministry of Health clinical psychologists cadre. Gaborone: Directorate of Public Service Management.Directorate of Public Service Management. (2013). Botswana public service competency based career path for Ministry of Health clinical psychologists cadre. Gaborone: Directorate of Public Service Management.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L., & Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet 378,(9803),1664-1675. doi.org/10.1016/S0140-6736(11)61458-X

Eltayeb, S., Sliep, Y., & Muneghina, O. (2017). Bridging the gap in mental health and psychosocial services in low resource settings: a case study in Sudan. *Intervention , 15*(2), 151 – 165.

Eriksson, M., Ghazinour, M., & Hammarstrom, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: what is their value for guiding public mental health policy and practice?. *Social Theory & Health*, *16,* 414–433. doi:10.1057/s41285-018-0065-6

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, *5*(1), 80-92.

Flick, U. (2018). Doing Qualitative Data Collection – Charting the Routes. In U. Flick (Ed.), *The Sage handbook of qualitative data collection*, (pp. 3-16). Retrieved from https://methods.sagepub.com/base/download/BookChapter/the-sage-handbook-of-qualitative-data-collection/i318.xml

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal, 204*(6), 291-295.

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization*, *78* (4), 475-482.

Hanlon, C., Fekadu, A., Jordans, M., Kigozi, F., Petersen, I., Shidhaye, R., Honikman, S., Lund, C., Prince, M., Raja, S., Thornicroft, G., Tomlinson, M., & Patel, V. (2016). District mental healthcare plans for five low and middle-income countries: Commonalities, variations and evidence gaps. *The British Journal of Psychiatry*, *208*, 47–54. doi: 10.1192/bjp.bp.114.153767

Jack, H., Wagner, R.G., Petersen, I., Thom, R., Newton, C. R., Stein, A., Kahn, K., Tollman, S., & Hofman, K. J. (2014). Closing the mental health treatment gap in South Africa: A review of costs and cost-effectiveness. *Global Health Action*, 7(1), 1-11. doi: 10.3402/gha.v7.23431

Janse van Rensburg, A., & Fourie, P. (2016). Health policy and integrated mental health care in the SADC region: strategic clarification using the Rainbow Model. *International Journal of Mental Health Systems, 10*(49), 1-13. doi: 10.1186/s13033-016-0081-7

Jenkins, R., Kiima, D., Njenga, F., Okonji, M., Kingor, J. Kathuku, D., & Lock, S. (2010). Integration of mental health into primary care in Kenya. *World Psychiatry, 9*(2), 118- 120.

Joffe, H. (2012). Thematic analysis. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209-223). Retrieved from https://www.academia.edu/26140328/Thematic_Analysis

July, E. (2009). Awareness, attitudes and referral practices of health care providers to psychological services in Botswana. (Master's Dissertation). Retrieved from http://contentpro.seals.ac.za/iii/cpro/DigitalItemViewPage.external?sp=1008653

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., Saxena, S., & Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet, 378*, 1654–63.

Kgosidintsi, A. (1996). The role of the community mental health nurse in Botswana: The needs and problems of carers of schizophrenic clients in the community. *Curationis*, *19*(2), 38-42.

Kigozi, F.N., & Ssebunnya, J. (2009). Integration of mental health into primary health care in Uganda: Opportunities and challenges. *Mental Health in Family Medicine*, 6, 37–42.

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry*, *15*, 402-405.

Macbeth, D. (2001). On "Reflexivity" in qualitative research: Two readings, and a third. *Qualitative Inquiry, 7*(1). 35-68. Retrieved from file:///E:/Methodology%20Articles/Douglas%20Macbeth%20Reflexivity%20(2001).pdf

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *The All Ireland Journal of Teaching and Learning in Higher Education, 9*(3), 3351-33514.

Maphorisa, M. K., Poggenpoel, M., Myburgh, C. P. H. (2002). Community mental health nurses' experience of decentralised and integrated psychiatric-mental health care services in the Southern mental health region of Botswana (part 1). *Curationis, 25*(2), 22-29.

Marshall, C., & Rossman, G. B. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, California: Sage Publications.

Mason, J. (2002). *Qualitative researching*. (2nd ed.). Retrieved from http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Mason_2002.pdf

McDaniel, S. H., & deGruy, F. V. (2014). An Introduction to Primary Care and Psychology. *American Psychologist, 69,*(4), 325–331. doi: 10.1037/a0036222

Ministry of Health. (2003). National policy on mental health. Retrieved from: http://www.moh.gov.bw/Publications/policies/mental_health_policy.pdf

Mkhize, N., & Kometsi, M. J. (2008). Community access to mental health services: Lessons and recommendations: Primary health care programme areas. South African Health Review, 2008(1), 103-113.

Monteiro, N. M. (2015). Addressing mental illness in Africa: Global health challenges and local opportunities. *Community Psychology in Global Perspective, 1*(2), 78-95.

Mugisha, J., Abdulmalik,J., Hanlon, C., Petersen, I., Lund, C., Upadhaya, N., Ahuja, S., Shidhaye, R., Mntambo, N., Alem, A., Gureje, O., & Kigozi, F. (2017). Health systems context(s) for integrating mental health into primary health care in six Emerald countries: a situation analysis. *International Journal of Mental Health Systems, 11*(7), 1-13. doi: 10.1186/s13033-016-0114-2

Nkomazana, O., Peersman, W., Wilcox, M., Mash, R., & Phaladze, N. (2014). Human resources for health in Botswana: The results of in-country database and reports analysis. African Journal of Primary Health Care & Family Medicine, 6(1), 1-8. doi:10.4102/phcfm.v6i1.716

Norum, K. E. (2008). Natural Setting. In L. Given (Ed.), *The Sage encyclopedia of qualitative research methods* (pp. 552), Retrieved from http://methods.sagepub.com/base/download/ReferenceEntry/sage-encyc-qualitative-research-methods/n282.xml

Omar, M. A., Green, A. T., Bird, P. K., Tolib, M., Flisher, A.J.,Kigozi, F., Lund, C., Mwanza, J., Ofori-Atta, A. L., & Mental Health and Poverty Research Programme Consortium (MHaPP). *International Journal of Mental Health Systems, 4*(24), 2-10.

Owolabi, E. O. (2012). Botswana. In W. Kirsten & R. C. Karch (Eds), Global Perspectives in Workplace Health Promotion. (pp. 21-40). Retrieved from https://publish.jblearning.com/index.php?mod=jbbrowse&act=book_details&id=650#

Padfield, L. (2013). Reframing the frame: Reflections of a community service psychologist. *Psycho-analytic Psychotherapy in South Africa*, *21*(1), 61-92.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J.P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533–544. doi:10.1007/s10488-013-0528-y

Patton, M. Q. (2015). *Qualitative research and evaluation methods* (4th ed.). Thousand Oaks, California: Sage Publications.

Petersen, I., Ssebunnya, I., Bhana, A., Baillie, K. & MhaPP Research Programme Consortium. (2011). Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. *International Journal of Mental Health Systems, 5*(8), 1-12.

Pheko, M. M., Monteiro, N., Kote, M., & Balogun, S. (2013). The development of the psychology discipline in Botswana: Research so far. Asian Journal of Social Sciences & Humanities, 2(2), 394-412.

Pillay, A. L., & Harvey, B. M. (2006). The experiences of the first South African community service clinical psychologists. *South African Journal of Psychology, 36*(2), 259-280.

Pillay, A.L., Kramers-Olen, A. L., Kritzinger, A.M., & Matshazi, V. (2012). Experiences of clinical psychologists working in public health service facilities. *Journal of Psychology in Africa*, *22*(4), 663–670.

Plattner, I. E., & Moagi-Gulubane, S. (2010). Bridging the gap in psychological service delivery for a developing country: Teaching the bachelor of psychology degree in Botswana. *Journal of Psychology in Africa, 20*(1), 155–160.

Reuter, P. R., McGinnis, S.M., & Reuter, K. E. (2016). Public health professionals' perceptions of mental health services in Equatorial Guinea, Central-West Africa. *Pan African Medical Journal, 25*(236), doi: 10.3402/gha.v7.24589

Richards, L. (2009). *Handling qualitative data: A practical guide* (3rd ed.). London: Sage Publications.

Roberts, B. (2007). *Getting the most out of the research experience: What every researcher needs to know*. London: Sage Publications.

Roulston, K. (2010). *Reflective Interviewing: A guide to theory and Practice.* London: Sage Publications.

Safarjan, B. (2002). A Primer for advancing psychology in the public sector. American Psychologist, 57(11), 947-955.

Saldaña, J. (2009). *The coding manual for qualitative researchers*. London: Sage Publications.

Saltman, R. B., & Ferroussier-Davis, O. (2000). The concept of stewardship in health policy. *Bulletin of the World Health Organization, 78*(6), 732-739.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *Lancet* ,*370*, 878–89. doi:10.1016/S01406736(07)612392

Schwandt, T. A. (2007). *The Sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, California: Sage Publications.

Seitio- Kgokwe, O., Gauld, R. D. C., Hill, P. C., & Barnett, P. (2014). Assessing performance of Botswana's public hospital system: The use of the World Health Organization Health system performance assessment framework. International Journal of Health Policy Management,3(4), 179-189. doi: 10.15171/ijhpm.2014.85

Seitio-Kgokgwe, O., Gauld, R.D.C., Hill, P.C., & Barnett, P. (2016) Analysing the Stewardship Function in Botswana's Health System: Reflecting on the Past, Looking to the Future. International *Journal of Health Policy and Management, 5*(12), 705–713. doi:10.15171/ijhpm.2016.67

Seloilwe, E.S., & Thupayagale-Tshweneagae, G. (2007) Community mental health care in Botswana: Approaches and opportunities. *International Nursing Review, 54*, 173–178.

Semrau, M., Evans-Lacko, S., Alem, A., Ayuso-Mateos, J.L., Chisholm, D., Gureje, O., Hanlon, C., Jordans, M., Kigozi, F., Lempp, H., Lund, C.,Petersen, I.,Shidhaye., R., & Thornicroft, G.(2015). Strengthening mental health systems in low- and middle-income countries: The Emerald programme. *BMC Medicine, 13*(79). 1-9. doi: 10.1186/s12916-015-0309-4

Silverman, D. (2001). *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage Publications.

Smith, S.L., Kayiteshonga, Y., Misago, C. N., Iyamuremye, J. D., d'Arc Dusabeyezu, J., Mohand, A. A., Osrow, R. A., Anatole, M., Daimyo, S., Uwimana, E., Dushimiyimana, D., & Raviola, G. J. (2017). Integrating mental health care into primary care: The case of one rural district in Rwanda. *Intervention 15*(2), 136 – 150.

Swarts, B. (2013). A community (dis)service: Reflections of a community service clinical psychologist. South African Journal of Psychology, 43(1), 105–115. doi:10.1177/0081246312474420

Szabo, C. P. (2013). Improving mental health systems in Africa. *African Journal of Psychiatry, 16*(6), 387 – 391.

Szabo, C.P., Fine, J., Mayers, P. , Naidoo, S., Zabow, T., & Mental Health Leadership Working Group. (2017). Mental health leadership and patient access to care: A public–private initiative in South Africa. *International Journal of Mental Health Systems, 11*(52),

Tsirikos, A. (2012). Introduction to applied thematic analysis. In G. Guest, K. M. MacQueen, & E. E. Namey (Eds.), *Applied thematic analysis* (pp. 3-19). Retrieved from https://www.academia.edu/6902223/INTRODUCTION_TO_APPLIED_THEMATIC_ANALYSIS

Tullis Owen, J. A. (2008). Naturalistic inquiry. In L. Given (Ed.), *The Sage encyclopedia of qualitative research methods* (pp. 548-550), Retrieved from http://methods.sagepub.com/base/download/ReferenceEntry/sage-encyc-qualitative-research-methods/n280.xml

Van Wyk, S., & Naidoo, A. V. (2006) Broadening mental health services to disadvantaged communities in South Africa: Reflections on establishing a community based internship, Journal of Psychology in Africa, 16:2, 273-281. doi.org/10.1080/14330237.2006.10820131

Walsham, G. (2006). Doing interpretive research. *European Journal of Information Systems, 15,* 320–330. Retrieved from file:///E:/Methodology%20Articles/Walsham%20(2006)%20Doing%20Interpretive%20Research.pdf

Willis, J. W. (2007). History and foundations of interpretivist research. In J. W. Willis (Ed.), *Foundations of qualitative research: Interpretive and critical approaches*, (pp. 95-146). Retrieved from https://methods.sagepub.com/base/download/BookChapter/foundations-of-qualitative-research/n4.xml

World Health Organization. (2017). *Depression and other common mental disorders: Global health estimates.* Retrieved from http://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf;jsessionid=25EBCF7E0522FB917E4783E4B9048434?sequence=1

World Health Organization. (1978). Declaration of Alma ata: International Conference on Primary Health Care, USSR, 12 September 1978.

World Health Organization. (2003). Quality improvement for mental health (mental health policy and service guidance package). Geneva, Switzerland: Author. Retrieved from http://www.who.int/mental_health/resources/en/Quality.pdf

World Health Organization. (2005). Mental health atlas. Geneva, Geneva, Switzerland: Author. Retrieved from http://www.who.int/mental_health/evidence/atlas/global_results.pdf?ua=1

World Health Organization. (2007a). *Integrating mental health services into primary health care.* Retrieved from http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf

World Health Organization. (2007b). *Monitoring and evaluation of mental health policies and plans.* Retrieved from http://www.who.int/mental_health/policy/services/14-monitoring%20evaluation_HKprinter.pdf?ua=1

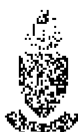
World Health Organization. (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group.* Retrieved from http://apps.who.int/iris/bitstream/handle/10665/44257/9789241563949_eng.pdf?sequence=1

World Health Organization. (2011). *Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level*. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/23741/B130_9-en.pdf?sequence=1

World Health Organization. (2013). *Mental health action plan 2013-2020*. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf?sequence=1

Yanchus, N. J., Periard, D., Moore, S. C., Carle, A. C., & Osatuke, K. (2015). Predictors of job satisfaction and turnover intention in VHA mental health employees: A comparison between psychiatrists, psychologists, social workers, and mental health nurses. Human Service Organizations: Management, Leadership & Governance, 39(3), 219-244, doi: 10.1080/23303131.2015.1014953

Appendix A: University of Pretoria Ethical Clearance



Faculty of Humanities
Research Ethics Committee

8 May 2018

Dear Ms Solomon

Project:	**The work-related experiences of psychologists in public health facilities in Botswana**
Researcher:	**WT Solomon**
Supervisor:	**Dr AA Gildenhuys**
Department:	**Psychology**
Reference number:	**12281485 (GW20180124HS)**

Thank you for your response to the Committee's correspondence of 22 March 2018.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 8 May 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

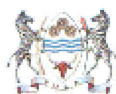
Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Dr AA Gildenhys (Supervisor)
Prof T Guse (HoD)

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr K Booyens; Dr A-M de Beer; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder Andrew; Dr E Johnson; Dr W Kelleher; Mr A Mohamed; Dr C Puttergill; Dr D Reyburn; Dr M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

Appendix B: Ethical clearance from the Ministry of Health

PRIVATE BAG 0038
GABORONE
BOTSWANA
REFERENCE:



TEL: (+267) 363 2500
FAX: (+267) 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

MINISTRY OF HEALTH AND WELLNESS

REFERENCE NO: HPDME 13/18/1 XI **01 September 2017**

Health Research and Development Division

Notification of IRB Review: **New application**

Warona Solomon
P.O. Box 80354
Gaborone

Dear Warona Solomon

Protocol Title: **THE WORK-RELATED EXPERIENCES OF PSYCHOLOGISTS IN PUBLIC HEALTH FACILITIES IN BOTSWANA**

HRU Approval Date:	01 September 2017
HRU Expiration Date:	31 August 2018
HRU Review Type:	Expedited Review
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health and Wellness within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

Vision: *A Healthy Nation by 2036*
Values: *Botho, Equity, Timeliness, Customer Focus, Teamwork, Accountability*

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A7 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kgmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr Kgomotso Motlhanka at kgmotlhanka@gov.bw at 3632751. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours faithfully

Ms S. Mosweunyane
for/PERMANENT SECRETARY

Appendix C: Ethical clearance from the hospitals

TELEPHONE: 5906300
FAX: 5915055
TELEGRAM: NGAKA

SCOTTISH LIVINGSTONE HOSPITAL
PRIVATE BAG 001
MOLEPOLOLE

Warona Solomon
P.O.Box80354
Gaborone

09/04/2018

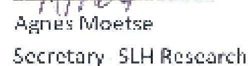
REQUEST TO DO RESEARCH ON THE WORK RELATED EXPERIENCES OF PSYCHOLOGISTS IN THE PUBLIC FACILITIES IN BOTSWANA

This is to inform you that ethics and research committee reviewed and approved your request stated above.

Please ensure that;

1. The information collected from the participants is treated in an ethical manner that is confidentiality should be maintained.
2. Participants consent should be sought
3. Necessary arrangements are in place to avoid interference with staff coverage of their work stations
2. Additional consent for photocopying some documents or taking photographs should be requested from the hospital superintendent

Dr Kalenga
Hospital Superintendent II



Agnes Moetse
Secretary SLH Research

Appendix D: Consent Letter to Participants

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

The work- related experiences of psychologists in public health facilities in Botswana.

Dear Participants

You invited to participate in a study exploring the working experiences of psychologists in public health settings in Botswana as part of the researcher's dissertation.

The study aims to explore what the experience of being integrated into public health settings is like for psychologists. This is inclusive of challenges faced, feelings, perceptions and perspective on the experience.

Psychologists were integrated into public health facilities to provide the public with access to affordable and accessible psychological services, specifically to tackle the social and psychological problems faced in society.

This will require about one to two hours of your time in which you will be interviewed at a location of your choice. The interview will be recorded digitally.

You will be given the opportunity to withdraw from the study at any point for whatever reason with no penalties. Your participation is completely voluntary and if you wish to withdraw, your responses will be removed from the study to respect your wishes. There is no anticipated psychological harm that may befall you or any activities that may put you at risk. Should the interview evoke any discomfort, arrangement will be made to assist you.

You are assured that all the information you share with researcher will remain confidential. Your personal details will not be revealed at any point. Your identity will be concealed through a coding system and you will remain anonymous through the entire process. You are assured that this information will be kept secure by the researcher and the University of Pretoria under the Faculty of Humanities. The data is stored in the university repository for a minimum of 15 years as part of the university policy. As part of this policy data may also be re-used by other researchers in the department, however identifying details will be removed from transcripts and all research material.

The study has been reviewed and approved by both the psychology department and the Research Ethics Committee (ResCom) of the Faculty of Humanities. Ethical clearance was granted by the Ministry of Health and the University of Pretoria.

The research results will be presented in the researcher's mini-dissertation and will be read by other psychologists and psychology students. You will be given access to the results obtained from the study. It is hoped that the information obtained from this research will make a valuable contribution to the field of psychology.

Should you experience any emotional distress as a result of the interviews free counselling will be availed to you through a private practitioner (Dr Mphele, contact: +267 72131259).

The researcher and supervisor can be contacted for further information or matters related to the study by using the contact details below.

Miss Warona Solomon

Researcher

Email: warona88@gmail.com

Tel: + 27 789905647

Dr Assie Gildenhuys

Supervisor

Email: Assie.Gildenhuys@up.ac.za

Tel: +27 12 420 2541

Declaration

I ……………………………………………………………………………… (Name and Surname) hereby declare that I fully understand what is written in this document and understand the purpose and procedures of this research project. I have been given a chance to ask questions and understand that I may withdraw without any penalties. I understand that by signing this form I am voluntarily consenting to participate in the study.

SIGNATURE OF PARTICIPANT DATE

……

WITNESS DATE

……

Appendix E: Interview Schedule

Interview Schedule

Contextual and work related demands

1. Could you please tell me about how you started working in a public health setting?
2. What services do/did you offer on a daily basis?
3. What are your roles and responsibilities in the public health facilities?
4. Could you please tell me about your work environment?

The Experience

5. Could please tell me about your general experience of working in a public health facility?
6. What is your experience of working with patients within the public health setting?
7. Is/ was there a support system available to you? (Yes/No)
   a. Could you please tell me about your experiences of these support systems?
8. Could you please tell me about your experience of the regulating and governing body in your work environment?
9. How would you make meaning of your experience in a public health setting?
10. Is there anything else you would like to add?

Appendix F: Initial Codings

Respondent1 (R1) Coding Table		
Initial Codes	**Data Sample/ Quotation**	**Respondent/ location of data sample**
• The respondent has been working in the public health setting for a long period time • He has served at two public hospitals one for seven years and another for two years	Actually I started working in 2009, I started at ……..Hospital. I had worked there for around seven years then I was transferred on promotion to Princess Marina Hospital where I worked about seven months then I was transferred here, at the ……..Hospital. So here I am now	R1. Pg1. Paragraph
• The respondent's work responsibilities were to offer individual counselling and group counselling	Basically Its one to one counselling or the group counselling that we do	R1. Pg1. Paragraph 4.
• Outreach programmes in the form of psycho-educational programmes • Other work include attending presentations, some lectures and educational programmes	We go for maybe some presentations, some lectures [and] some educational programmes	R1. Pg1. Paragraph 4.
• Other duties included participating in committees such as quality improvement	other duties that we do as part of the hospital staff for example, we are also engaged in [the] hospital quality improvement committee	R1. Pg1. Paragraph 4.
• The respondent cares about providing quality psychological services • Prioritising quality services	At the end of the day when the patient is satisfied, that's when we can call it a quality psychological therapy	R1. Pg1. Paragraph 5.
• Adjusting psychological models to fit the patient	Sometimes we need to restructure it in a way so that you can actually deliver to the patient and the patient understands	R1. Pg2. Paragraph 1.
• Differences in language causing some communication difficulties.	Yes, obviously it's a factor because Setswana, we are not really fluent and we don't understand that much about Setswana even so	R1. Pg2. Paragraph 2.
• Language as a minor barrier to therapeutic treatment	This one like you know, as I said, I've been working nine years but really I did not feel this is really a big challenge	R1. Pg2. Paragraph 2.
• Normalising the language barrier to put clients as ease	when I give the briefing you know, at the beginning of the session I try to normalise that	R1. Pg2. Paragraph 2.
• The department consists of two foreign clinical psychologists and two interns	We have two psychologists. Two are foreigners both... But we have interns who are, and they are two and currently we have an attaché. She just... For one and a half months. So its basically two of us and two interns.	R1. Pg3. Paragraph 2.
• Modifying the work	Yes, we all do sessions on a daily basis. We have our	R1. Pg3. Paragraph 3.

schedule in order to manage the constraints/ limited space • Seeing patients in the ward to create space for consultation in the office	schedule you know. We have a booking books/diary but due to our work constraints in terms of space, maybe we won't be able to, all of us, see patients at the same time in the department because we are four and we have two rooms, but we do also see patients in the ward. So maybe two are seeing patients and other two are maybe seeing patients in the ward or maybe doing some other administrative work in the office	
• Constant inflow of clients • The department remains fully booked	Yes, I'd say, because we deal with a lot of patients.	R1. Pg3. Paragraph 4.
• Prioritising emergency cases even with a full schedule • Judicious management of patient load	That we give priority. We see them within [a] full 24 hours especially para-suicide or sexual assault cases	R1. Pg3. Paragraph 4.
• Making an effort to provide comprehensive care • Making an effort to meet the patient's needs	If the patient is stable [then] we discharge them from the hospital then we give them a date according to their condition, considering the condition.	R1. Pg3. Paragraph 4.
• Shortage of space and therapists • Barriers to treatment both patient and departmental • Patients' life circumstances may at times cause a barrier to treatment	we have a shortage of our therapists and space but there are also barriers from the patient's side as you mentioned [before] distance,	R1. Pg4. Paragraph 1.
• Psychology was not a well-known concept when hospitals were built • The respondent provides a possible reason for the lack of space for the psychology department	I think when they were built, psychology department(s) or [the] psychology idea was not that prominent maybe in the health sectors	R1 Pg5. Paragraph 2.
• A need for more psychologists • A need for psychological intervention in the community	We need more psychologists because really, the more patients that we are not actually [seeing]...	R1. Pg5. Paragraph 3.
• More child psychologists are needed in the department	Yes, we do see some child patients but because we do not really have child psychologists	R1. Pg5. Paragraph 3.
• The department is need of treatment facilities for children	Also, we do not have the setup here. We do not have play therapy rooms	R1. Pg5. Paragraph 3.
• Recruited from Bangladesh to Botswana public health by the Botswana government	A team went to Bangladesh from Botswana actually before that, we had seen some adverts from the newspapers that Botswana government wants to employ some psychologists	R1. Pg6. Paragraph 9.
• Other health professions	Actually it was not only psychologists, even some	R1. Pg6-Pg7.

were also recruited through this initiative	other health professionals including doctors, physiotherapists, dieticians, radiologists, pharmacists [and] all those things	Paragraph 9
• Receiving support from fellow health professionals	No, the colleagues are fine. I would say everybody is supportive [and] they try even as I said, when you go the wards and we need some interpretation the nurse says... and then others and they help so its fine in terms of supporting	R1. Pg7. Paragraph 4.
• Getting support from hospital management • Support from other clinicians	Management, from management, I think we get support as much as possible from them. From the clinical side we have also support services.	R1. Pg10. Paragraph 2.
• Other health professionals confused about when to discharge patients who still need psychological treatment • Limited/Restricted understanding of the therapeutic interventions leading to early discharge	some challenges in terms of when you want to discharge the patient, there maybe some do not understand the psychological therapy and other parts like I would say they would just discharge the patient maybe without informing you, maybe the patient wants to go home so they will just discharge or sometimes they would just refer to you say like 'discharge via psychology'	R1. Pg 7. Paragraph 4.
• Communication gap between professionals	maybe there's a communication gap	R1. Pg7. Paragraph 5.
• The respondent is satisfied with the public health setting	Public health facilities I would say, Its ok. I'm satisfied with it. Yes, I understand the challenges of public health facilities	R1. Pg8. Paragraph 4.
• Patients satisfied with the services offered	Yes, I said we have challenges but at the end of the day I think our patients are happy and we are happy also	R1. Pg8. Paragraph 5.
• Coping with the environmental limitations by accepting the conditions within the public health setting	As I said that the first thing is the understanding it you know	R1. Pg9. Paragraph 1.
• The respondent sees a variety of serious psychological problems from adjustment disorders to relational problems and social problems • The respondent has to attend to number of serious psychological disorders such as para suicides and sexual assault	We have adjustment disorders, depression, anxiety, para-suicide [and] sexual assault cases. We also see relationship problems a lot. Social issues, we attend social issues as well maybe the psychological problem that is triggered by social problems	R1. Pg9. Paragraph 3
• The respondent had no concerns with policies and	We [also] have our hospital best [practises] policies and procedures/guidelines	R1. Pg10. Paragraph 6.

guidelines		
• Starting the department from the beginning	There was no clinical psychology department there so I had to establish the department	R1. Pg11. Paragraph 3.
• Building the foundation of psychology in Botswana •	so I think I would say that is how actually we have started psychology in Botswana	R1. Pg11. Paragraph 3.

Respondent 2 (R2) Coding Table		
Initial Codes	**Data Sample/ Quotation**	**Respondent/ location of data sample**
• Recruited into the public health setting through the Ministry of health	I got a job offer with the Ministry of Health and [was] posted to a town four hundred kilometres [away	R2. Pg1. Paragraph 1.
• Prior to obtaining a master's degree in Clinical psychology the respondent worked in the public health facility	I started in August, 1999. September, 2000. I returned to school, returned June of 2004 and left December/end of November, 2005. Actually, 2004. So a few months in 2004 and a little over a year in 1999	R2. Pg1. Paragraph 3.
• Introduction to the public health setting • Through this experience the respondent gained a lot of knowledge • The respondent's main duties were to conduct intake interviews, translation and in-service lectures to staff	It was a learning experience because I didn't know what to expect [or] what not to expect so I went in with an open mind to learn and most of what I was doing in my line of work as a first degree holder, was the simple intake interviews and a lot of translating for non-setswana speaking doctors and some in-service lectures to the staff.	R2. Pg1. Paragraph 4.
• Training abroad • No training for psychology at the local university back in 2000.	Yes. We didn't really, then I don't know about now, we didn't really offer psychology. Back then, psychology wasn't offered at the local university and I was going back for my second degree. If the first degree wasn't offered then obviously the second wasn't offered so I went abroad for my second [degree].	R2. Pg1. Paragraph 7.
• The respondent's formal appointment as a clinical psychologist began in July 2004.	I started working as a clinical psychologist in July of 2004 after I graduated with my masters degree in clinical psychology in Francistown	R2. Pg2. Paragraph 2.
• There were two newly graduated clinical psychologists when she began working in public service as a clinical psychologist	Right around this time that I arrived, [there were] two other newly graduated psychologists who unlike me, did not have a break between their first degree and the second degree. So from their first degree, they immediately proceeded to their second degree whereas I had a break so we were only three of us [in total	R2. Pg2. Paragraph 4.
• The respondent assumed a senior position because of her previous experience in public service and her age.	Everything that a psychologist does. I was senior to them in that they were new in the public [service field] and I had technically been in public service since 1999 so seniority was automatically assumed and I was not their age so again, the age factor made it obvious that I was senior to them but then officially, I was senior to them as well	R2. Pg2. Paragraph 5.
• Reviving a department that had been dormant for approximately six years	We were essentially setting up a department that had been neglected, that had been put on the back burner for about five/six years because when I applied for a job in 1999	R2. Pg2. Paragraph 5.
• The respondent describes	completion of my first degree, I was applying	R2. Pg2. Paragraph 5.

how she was finally posted at a local referral hospital • Respondent went through several processes to find a suitable post	specifically to Lobatse because that's my home town and my second choice was Princess Marina Hospital but I was told the post in Princess Marina was already occupied and the only vacancy was in Francistown as well as the one in Lobatse, was also occupied so the only place available was in Francistown if I wanted the job with the ministry of health but then when I got to the job in Francistown the individual who had occupied the post in Marina had gone to understudy with the psychiatrist in Francistown because in Marina, there were no psychiatrists so he/she went to Francistown to be with psychiatrists, people in the similar profession so Marina was essentially vacant but Marina essentially, did not have psychologists because the individual was not there in person but [then] I couldn't assume that post because it had an owner even though the owner was in Francistown where I was posted. So we ended up being two in Francistown	
• Starting the department from the beginning • The respondent had to put in a lot of work to establish the department • Establishing the department required office allocation, purchasing furniture and stationery and introducing the psychology department to hospital staff	So in coming to Marina in December of 2004, it was to establish a department so [that meant] everything that goes into establishing a department from making your colleagues know of your existence [and to] know of your services, to making clients or patients know of your existence where in the mornings, as patients are queuing up to see doctors, we would have three and a half minute talks to them to say [that] there's this department that serves people in this way. It meant starting from the very basics of being allocated an office, finding furniture for that office, finding stationary, finding cleaning material [and] everything [else].	R2. Pg2. Paragraph 5.
• Being thrust into a senior position • Starting the department with limited experience and limited guidance from the hospital • Laying down the foundation for psychology in the hospital •	Here's this, you are the head of psychology. There's no psychology In ….. essentially. See what to do with it."	R2. Pg3. Paragraph 3.
• Tailoring the services to the hospital's needs • According to the respondent the services were designed to attend to the psychological component of physical	physical ailments and disorders and diseases so in tailoring the services that we offered, obviously it wouldn't be in the lines of psychiatric disabilities or disorder	R2. Pg3. Paragraph 4.

ailments		
• Busy department • Response from the hospital • Receiving plenty of referrals from different health professions in the hospital • Constant flow of work within the department • The department an overwhelming amount of patients	It was not a sleeping department. It was a busy department. I guess that speaks to what the response was like. We would get referrals from every department in the hospital, from the out patients department, from surgery, from the theatre room... We'd get referrals from the pharmacy, we'd get referrals from other out-lined professionals - the physiotherapists, dieticians and occupational therapists, the speech and audio specialists... So everybody who was at ……. would refer [patients] to our department and we too in turn, would refer [patients] to disciplines that we thought would further assist the client.	R2. Pg3. Paragraph 5.
• Serving the whole country • Providing services to a large population • Working in one of the main referral hospitals meant that patients were referred from all over the country	You'll recall too, that ……is a referral hospital which means it was servicing the whole of Botswana. The department as a result, was servicing the whole of Botswana. The numbers may not have been astronomical coming from the periphery but we did have our fair share of referrals from the hospital as well as walk-ins	R2. Pg3. Paragraph 6.
• Managing the caseload by distributing patients among the three psychologists • Dividing the patient caseload according to each psychologist's field of expertise	and the client load was divided among the three of us with each one of us knowing the other's strengths	R2. Pg4. Paragraph 1.
• Patient attendance determines the kind of work day • Offering outreach services across the country	another thing that would happen is going on outreach to the furthest point of the country to offer services there so on a hectic day I could see seven patients	R2. Pg4. Paragraph 2.
• Patients seemed to have limited knowledge about the purpose of psychological referrals	"What has doctor so and so said you should come and see me about", "I don't know, the doctor said I should come and see you	R2. Pg4. Paragraph 3.
• Patients' expectations about the psychological services • Respondent observed that some patients were not sure what to expect when receiving psychological services	It's just that when people don't have previous experience, they genuinely don't know what it is.	R2. Pg4. Paragraph 4.
• Diverse patient population in the public health setting	As in... It's public health! Its open to everybody. You see the whole strata of society	R2. Pg5. Paragraph 2.

• The public health is clinical environment • Assisting patients with the psychological aspect of physiological problems • The respondent	It was a very clinical environment where... Did you know that the bulk of your clients are people that are coming in with a physiological problem maybe manifesting psychologically or a psychological problem manifesting physiologically	R2. Pg5. Paragraph 4.
• Dealing with a broad spectrum of psychological problems • Consulting terminal patients	instances of counselling to end-of-life patients in any department	R2. Pg5. Paragraph 4.
• Unpredictable work schedule • The respondent was not frustrated by the unpredictability of the work environment	It was unpredictable yet not frustrating in the process	R2. Pg5. Paragraph 4.
• The respondent recognised that she had a suitable personality for the unpredictable work space	Nothing is monotonous and it gelled well with my personality where I cannot stand monotony	R2. Pg5. Paragraph 5.
• An engaging work environment	It was diverse. It was not stagnant. It was always in motion.	R2. Pg5. Paragraph 5.
• The respondent consulted mostly adult males and females and very few pre-teen children • The males were more consistent in their attendance than females • A large number of female patients attended the first session	Both male and female. Very few numbers of pre-teen children and when I say both male and female, it would be on a 49 to 51 percent kinda thing but it would be the men who would be regular and constant in their follow up visits. The women would come in large numbers but only for the first visit, mostly only for the first visit but the men would see this is as a healing process, as a management that needed repeat visits	R2. Pg5. Paragraph 6.
• The respondent offers a possible explanation for the non-attendance of most female patients • She provides her observation of differences between men and women in addressing psychological issues. • Women are able to confide in each other whereas men prefer a more private space to resolve their psychological problems	They come in to initiate but they don't carry through and there are many factors that could be attributed to this. Is it that maybe they're home makers [and] they've got to be home at certain times of the day to take care of the children when they come from school. To prepare for them and take care of their families or if they're employed, they have to work twice as hard as compared to their male counterparts? Women experience has shown that most of them are not in high ranking offices. They would be juniors in their places of employment and for juniors to constantly be saying “I have a review in a weeks time” doesn't sit well as opposed to if it was a managing director, who says to his secretary “I'll be back”. So those factors also come into play or the fact that, because women are known to be people who speak out, perhaps after a session, they feel “I've had enough. I'm going to carry on with this and	R2. Pg6. Paragraph 2.

• Woman have a major responsibility in family life • Junior staff members experience hierarchical constraints may prevent adherence to treatment	now i'm able to speak to somebody else" whereas with males, it would be "i'm coming back here again so that I can continue this conversation". Having it as a "I'd rather keep it here rather than talk about it with my cousins" or other women folk as women would often times go and discuss with their cousins or friends [about] whatever it is that is going on in their lives and the men would often just not want to talk about it anywhere else	
• Testament of a positive treatment outcome • Patients approaching the respondent to show appreciation for her assistance	"You know your child really took me out of the dark whole".	R2. Pg6. Paragraph 3.
• Therapy drop-outs denied other patients the opportunity of getting earlier appointments	It was rather unfortunate because it meant that the next person who could've been booked for Wednesday at eleven o'clock has now been put two weeks further down	R2. Pg6. Paragraph 4.
• Working in the public health setting as rewarding experience • Working in the public health enhanced the respondent's professional experience and knowledge • The respondent's experience in the public health setting has developed her capacity to work with a wide spectrum of patients	It was a fulfilling learning experience because I know that had I plunged into private practise, I would've got a different crop of clients, of a different mindset whereas in the public health sector, I got the whole spectrum of characters, of anything that you can expect in a human being. It really was open. You could get anything off clients and that has helped me personally [and] professionally in that, it has made me a very open minded person who's vision is quite broad and not specific to trying to specialize if I may say, in more disorders only because that is what I see only. I've been able to deal with DSM 4 from page 46 to page 567	R2. Pg6. Paragraph 5.
• Respondent had to consult with disorders that she preferred not to work with and thus had an awareness of what she could and could not work with • She realised that she had some strengths in working with certain disorders • Because of her professional obligations, she still had to work with the disorders she did not like which displayed a/ her level of commitment	Of course! In that wide spectrum, there were disorders that I personally preferred not to work with because i'd feel [that] i'm not competent for this one or i'd feel it resembles an aspect of my life too much so i'm not going to handle that and others that... As a therapist, you know your weakness and strengths and of course its natural to want to capitalize on your strengths but at the same time being sure not to pay attention to your weakness because they could eventually become disabilities and in the process, you wouldn't be able to attend to these other grouping of disorders because you have paid no attention to making yourself aware and able to handle them. So as much as I have preferences, I still would attend to those that I didn't personally and professionally prefer.	R2. Pg7. Paragraph 1.
• Collegial support among	We, the trio of psychologists, would have debriefings	R2. Pg7. Paragraph 3.

three clinical psychologists in form of regular debriefings	every now and then it wasn't scheduled in our weekly calendar but we would have debriefings	
• Support from medical staff in the form medical advice • The respondent made efforts to gather as much medical information as she could to assist her patients • The respondent tried to gain a better understanding of her patients' medical conditions in order to provide comprehensive psychological support	Because I'm not a medical personnel, when there was a disorder that I didn't understand, the colleagues in the medical fraternity were always available to explain diabetes for instance, when I first collided with a client who presented with managing diabetes but from a psychological perspective. So I had to consult with physicians for that. When there was an instance of a teenage who had cancer of the bone and had to have a leg amputated, I'd first have to go for a beautiful learning session with the orthopaedic surgeon to explain to me what it is that he is going to do, how he is going to do it ,what the disease progression meant and all that such that by the time I go to meet with the client, then I appear intelligent so in the process I also learnt a lot about physiological disorders. I'm nowhere near being a doctor from the consultations that I had but I am well informed.	R2. Pg7. Paragraph 3.
• A sufficient amount of collegial support	Plenty.	R2. Pg7. Paragraph 5.
• Frustrations with colleagues regarding unclear referrals	"But Mrs M. We brought it to you because you are the psychologist. You can get into the brain" Really, Can It's frustrating on the sides of both the colleagues, myself and the referring professional	R2. Pg8. Paragraph 2.
• Ensuring that the patient is adequately assisted by referring back to other colleagues • Showing some concern over the patient's frustrations with the referral processes • Feeling disempowered when she is unable to assist clients such as the hearing impaired • Miscommunication between staff members about appropriate referrals	I'd refer back and then sit and wonder how my 'almost' client was and then continue with my … (inaudible speech) cause really when lets say, we're talking right now but we're speaking two different languages. There is no communication and ours is to listen as the person speaks and you speak back but if they can't hear you, how will you help?	R2. Pg8. Paragraph 3.
• In-service lectures as a means to discuss problems encountered within the	There would be periodic in-service lectures where for this quarter, the department would be given a lecture slot	R2. Pg8. Paragraph 5.

work place		
• Daily practice is governed by code of ethics • Abiding by code ethics prevents one from misconduct	You know, if you know your governing ethics of your profession, chances are that you are not going to contravene anything	R2. Pg9. Paragraph 1.
• The respondent values peer consultation • Peer consultation is a source of support especially in instances of diagnostics dilemmas	is the value of supervision of consultation, of peer reviews because if I'm not sure if I'm torn between two diagnosis	R2. Pg9. Paragraph 1.
• Choosing psychology as the most preferred career choice • Most inclined to psychology as a career choice • Displaying a high level of satisfaction with one's career choice	For me, it's where I say, if not psychology what is it that I'd be doing	R2. Pg10. Paragraph 1.
• Acknowledging her contribution in setting the foundation of psychology in the hospital.	had it not been for me, we would not have a psychology department with the foundation that was laid back	R2. Pg10. Paragraph 2.
• Patients in the hospital experienced better treatment outcomes as a result of being referred to the psychology department • The psychology department made a significant contribution to the hospital	Many [of the] clients that were referred to us with whatever physiological conditions, their outcomes were much better than those who were not referred	R2. Pg10. Paragraph 3.
• The development of a psychology department provided a way to manage many psychological disorders • Possibly adding to the knowledge of psychological disorders in the country and through treatment, showing Batswana the benefit receiving psychological assistance. • Psychology played a major role in management of physiological disorders	It did for Botswana. Something that had lacked for six years was it six... years... 98 99...(counting) Seven years, there about. Many physiological disorders become manageable when you have insight,	R2. Pg10. Paragraph 4.

Respondent 3 (R3) coding table		
Initial codes	**Data Sample/ Quotation**	**Respondent/ location of data sample**
• Active recruiting in Bangladesh lead to appointment in the public health sector	I applied to… Actually there was a circular of the recruitment in Bangladesh then I applied for this job. They went to recruit us, I went for the exam, I passed the exam and then I was recruited.	R3. Pg1. Paragraph 1.
• Respondent has had an extended experience in the public health setting. • Respondent had no previous work experience in the public health setting	In Botswana... Actually in Bangladesh I didn't work in [the] public health [setting]. That side I was working [in the] private [sector] but here for the first time I am working in the public health sector in Government. I came in 2010, 19th of January 2010. Its almost 9 years now working in the public service in Botswana	R3. Pg1. Paragraph 3.
• The respondent's main responsibility is to provide psychotherapy and counselling	In the hospital setting as a psychologist, my main responsibility is to provide psychotherapy and counselling. Do you know what the difference between counselling and psychotherapy is?	R3. Pg1. Paragraph 5.
• Psychology is defined as working in a relationship with patient using CBT • Documenting patient data as part of the work responsibilities/duties • Developing capacity through relevant topic discussions	Counselling is… Psychotherapy is more different than counselling, that we can say... generally we say counselling or psychotherapy inter-sensibly. So we provide psychotherapy. We deal with the patient, we provide psychotherapy. Actually we practice here CBT, Cognitive Behavioural Therapy, that one maybe if we find time we'll explain that one later. So this is the main task we do, providing psychotherapy then we have to also do other things like documentation. We have to document the patient's data then we have also in-service Lectures then what we do also in-service… (inaudible) maybe it happens once in a… when we find time [or when] we are more psychologists. We also have… maybe we'll be discussing any psychological topic to enhance our knowledge in psycho…	R3. Pg1. Paragraph 6.
• Weekly clinical supervision as part of formal continuous professional development	That is in-service… Case presentation we have. We also call it Clinical supervision. It happens once in a week this clinical supervision is there then that in-service is the part of CPD, Continuous Professional Development and we have also current case conference… maybe we have once in a quarter once in a month we do like this.	R3. Pg2. Paragraph 1.
• Discussing psychological topics • Keeping up to date with psychological topics • Discussion on how to manage different psychological disorders such as stress	Among us we'll be discussing psychological topics maybe we can discuss the symptoms of depression, management of depression, psychological management of depression, psychological management of schizophrenia like this we'd be discussing maybe stress management. Someone will present it to make us update	R3. Pg 2. Paragraph 2.

• Keeping up to date with the management of different psychological through departmental presentations		
• Attending in- service lectures • Departmental and inter-departmental in- service lectures to discuss all types of issues faced in the institution	broad one that one but our departmental level we discuss psychological issues only but we also [have] the in-service lecture in our hospital that one we discuss a lot of things - medical conditions	R3. Pg. 2 paragraph 3.
• Intention to Involve the family in therapy	we want to involve their family because family plays a vital role for a patients recovery or the outcome of the therapy	R3. Pg2. Paragraph 5.
• Getting the required accreditation	This is the requirement of the COHSASA. We're going through the accreditation process	R3. Pg2. Paragraph 5.
• Describing the institutional level job responsibilities • Managing psychological problems is the main job description.	Yeah, main thing (inaudible) the description is not really curative [but] to manage the psychological problem(s) at the hospital level. This is my job description.	R3. Pg3. Paragraph 4.
• Providing group therapy when necessary	we also provide group therapy sometimes when it is needed	R3. Pg2. Paragraph 6.
• Making therapy more effective through family involvement • Meeting COHSASA requirements	It is called COHSASA accreditation not only that one to make our therapy more effective we also involve the family especially for the child patient who are below 18 years. It is a requirement [that] we of course involve the family	R3. Pg2 - Pg3. Paragraph 6.
• Doing preventative work by providing educational programs	we also do preventative job like we do the PBRS, PBRS also we have how many in-service like educative programs we have like for substance abuse in a month at least one like we know... need to do also preventative work	R3. Pg3. Paragraph 3.
• Educating Batswana about mental health • Improving mental health awareness	we have big program educating people on mental health also because we know that like in Botswana, this mental health is not that much known to the people	R3. Pg3 Paragraph 3.
• Participating in annual performance management initiatives	That one is our, all the government employer in Botswana they have critical PBRS - Performance Based Reward System for every year I have to make my, it's called PDP - Performance Development Plan/Personal Development Plan maybe PDP. I have to have my objectives, what I'm going to do for the whole year ok	R3. Pg4. Paragraph 2.
• Developing treatment guidelines	We've also developed some SOP's and we have also developed some treatment guidelines for department	R3. Pg 4. Paragraph 2.

	and we follow	
• Commemorating World Suicide Prevention day	The other thing is 10th of September every year we also [observe] World Suicide Prevention Day, 10th of September so we also commemorate World Suicide Prevention Day	R3. Pg 3. Paragraph 3.
• Going for outreach programs • Conducting wellness programs for District Health Management Teams	We also go to prisons (inaudible) we have [the] Ikago centre here, when we are invited ok, like so (inaudible) we have also wellness programs for the DHMT for the district also.	R3. Pg4. Paragraph 1.
• Participating in committees to enhance your knowledge • Participating in committees	Part of… As I was saying that being part of the PIC member… I was part of the wellness committee member before as a psychologist. You have to be also [part of] other things [so] you can also learn [and] enhance your knowledge also	R3. Pg4. Paragraph 4.
• Working in a multi-disciplinary team • Working in an effective multi- disciplinary team	We have an effective team... (inaudible) every Thursday at half past 8, we meet all the professionals like psychologists, occupational therapists, physiotherapists, social workers, dieticians, nurses then medical officers then physicians [and] pharmacist	R3. Pg4. Paragraph 5.
• Advantages of working in a multi- disciplinary team	Of course, it is very good one and there are a lot of advantages when a patient has social issues [then] social workers	R3. Pg4. Paragraph 2.
• Describing the patient demographic • Case load is divided into three categories adults, 18 years and above children less than 10 and children less than 12 years • His consultations consist mostly of adult patients	I think you were also asking at the beginning, I can help you, what type of patient we see more here as you asked at the beginning maybe I didn't answer that one is it. Most of the patients are adult(s) and think that we have also approximately 25 to 30 per cent are children and if I say that maybe below 18 years maybe there will be 50 per cent patient are children	R3. Pg5. Paragraph 3.
• Types of psychological problems clients face • Most adults come to consultation for relational problems with partners or the family • The respondent also consultants a number of para-suicide patients along with depression and anxiety	Adult patient who are coming here most of them they have relationship problem maybe relationship problem with the partner, relationship problem with the family, relationship problem with parents. We and we also find quite a number of para-suicide patient who tried to commit suicide then we have also patient with the problem with depression and anxiety	R3. Pg5. Paragraph 3.

• Patient recovery as a motivating factor within the workplace • Patient recovery is encouraging to the psychologist and makes for a rewarding experience in the hospital	as a psychologist or as a clinician or as a therapist it will make you happy this is the encouragement or this is the reward for you for this reason we like to work in the hospital dealing with the patient	R3. Pg6. Paragraph 2.
• Saving a life • Making a difference • Creating hopefulness and re-establishing family relations	You are saving life	R3. Pg6. Paragraph 3.
• Limited means of professional growth	You know what we do as we are saying professional growth, we don't have that much training	R3. Pg6. Paragraph 4.
• Using clinical supervision, in-service and peer consultation as a source of professional growth • Creating own opportunities for professional growth	I've shared with you professional growth, we have clinical supervision and we have in-service lectures	R3. Pg6. Paragraph 4.
• No standardised tests for Botswana	I'm sorry to say that they're not standardised for Botswana though like we have that... (inaudible) one we have 4 sub tests, 2 sub tests are culture free like metric reasoning and	R3. Pg7. Paragraph 1.
• Finding innovative ways to use available resources. • Judicious use of limited resources	we write that this test is not standardised for Botswana but at least we can get some idea though it is not one 100 per cent	R3. Pg7. Paragraph 1.
• Sufficient provision of support with some limitations	We have all types of support from the hospital but we know that we don't have enough	R3. Pg7. Paragraph 6.
• Shortage of clinical psychologists	We get the support but the problem is that as we have less clinical psychologists in Botswana	R3. Pg7. Paragraph 6.
• Many foreign clinical psychologists in Botswana's public health setting	most of them we are actually foreigners we were 8	R3. Pg7. Paragraph 6.
• Heavy workload due to shortage of clinical psychologists	When someone is going on leave maybe then there will be less people to replace but sometimes the work load is high	R3. Pg7- Pg8. Paragraph 6.
• Managing heavy caseload by prioritising urgent cases	What we do by giving the priority which is the first priority which patient needs more urgent attention from us or urgent therapy	R3. Pg8. Paragraph 1.

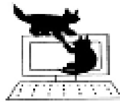
• Diligently adhering to COHSASA accreditation requirements • Successfully meeting the COHSASA accreditation requirements • Making a concerted effort to meet COHSASA accreditation requirements	We are doing well in our department we always get more than 95 per cent marks because we try our level best	R3. Pg8. Paragraph 4.
• Registration with Botswana Health Professions Council	Botswana Health Professional Council. First you have to register with them.	R3. Pg8. Paragraph 5.
• Providing mentorship for psychology and counselling students • Offering practical learning experience for psychology students. • Operating as an internship • Running an internship site for psychology students through the government internship programme	Another thing I want to share with you is that in this department especially in our department in this hospital, we also train students	R3. Pg8. Paragraph 6.
• Working in the public health setting is a good experience	Yes, it is good to work in public health sector	R3. Pg9. Paragraph 3.
• Working in the public health setting affords one the opportunity to work with a lot of people • Gaining a lot of experience from working in the public health setting • Helping a large number of people	There are some advantages... (inaudible) but there is no problem working in public sector. You will be interacting with a lot of people you will be helping a lot of individuals also you'll get a lot of experience	R3. Pg9. Paragraph 3.
• The benefit of working in a public health facility is a stable salary	These are the advantages, you'll work up toward end of the month you'll get a salary but money wise in public it is a fixed on	R3. Pg 9. Paragraph 3.
• Comparing the benefits of private practice with the public service	private if you work harder harder harder you can get more money also these are the advantages for private one and disadvantages for the public one	R3. Pg9. Paragraph 4.
• Working in the public	you will not have more stress, you'll be more relaxed	R3. Pg9. Paragraph 5.

service is less stressful • Reduced working hours compared to private practice • less pressure to work long hours for more pay	because you will not be tempted to go for more money	
• Autonomy in private practice versus following procedures and guidelines in public health • Disadvantage of working in public health • Reviewing the pros and cons of both private practice and public health	In private also there is advantage, you will be autonomous but government you are not autonomous	R3. Pg9. Paragraph 6.
• A need for more clinical psychologists	We need more clinical psychologists here in Botswana. It is too much work	R3. Pg9. Paragraph 7.
• Clinical psychology should be promoted in Botswana	So we should promote clinical psychology profession in Botswana.	R3. Pg9- Pg10. Paragraph 7.
• The importance of having an extended family • Sharing problems with the extended • Changes in the family set up have led to the development of psychological problems •	Yeah, so if i say I'll go to social... (inaudible) like we had extended family before, extended family. Now we have nuclear family. If someone has any problem maybe sharing he or she can share. Our upbringing is not like the previous one because we find a lot of child patient who has problem with speech because the parents both of them, will be working there's nobody to talk to them like previously the elderly people they were together the family members will be there, they will be talking, the baby will be talking also the child will be talking, this is the giving the example so now	R3. Pg10. Paragraph 1.
• More psychological problems due to urbanisation • Societal pressures leading to psychological problems	we are more isolated so we have more psychological problems now it is contributing due to the urbanisation	R3. Pg10. Paragraph 1.
• Competition for employment contributes to the development of psychological disorders such as depression • (Past generations)	And if i say a lot of challenges are there, also you know that now only here in the whole world now unemployment is a challenge also because lot of competition are there who are not maybe capable to survive in the competition they are depressed now but maybe think that 30, 40 or 50 years before there was not that much competition you know that...	R3. Pg 10. Paragraph 2.

People from 30, 40 50 years ago did not have to deal with high levels of competition for work and therefore were less prone to psychological problems • The respondent made an effort to give his perspective on some of the societal issues such as modernisation and urbanisation • Advancements in technology as contributing factors	(inaudible) who did form 3 before, 30 years before who did form 5 20 years before, they were doing job. Now we can see a lot of graduates are there, degrees, they did degree but they are not working now. A lot of competition is there now due to the modernisation or urbanisation and another thing also because we have less job now we used to do the manual job now, now we have a lot of electrical tools now the devices are there you don't need more people to work there the machine can work now.	
• The respondent stresses the importance of training in psychology especially encouraging students from as early as secondary school to enrol in psychology courses leading up to masters in clinical psychology	Yeah, it should start from the beginning like maybe like when someone is going to study after form 5, they can go to study psychology then after psychology also they should do degree in psychology, they should do also masters in clinical psychology or any applied psychology and I think that another thing, there also who are the psychologists working in Botswana I know that we have a psychology association	R3. Pg10. Paragraph 3.
• Developments in psychology should be made by the psychology association	Psychology association also has more responsibilities according to me they should also negotiate with government	R3. Pg10. Paragraph 3.
• Recommendation by the respondent for the psychology association to develop psychology in other sectors such as the education, industrial sector and other sectors • Recommendation by the respondent to create jobs for psychologists once they have been trained	negotiate with government like not only ministry of health, the psychologist can also work the education sector, the psychologist can also work in the education ministry then some industrial psychologist they can also work in the industrial industry so the psychology association has more responsibilities according to me to promote the psychology to motivate people or the students to study psychology same time also they have to also negotiate for creating job for psychologists we need to	R3. Pg10. Paragraph 3.
• The psychology association needs to be more active in developing the profession.	They should be more proactive, they need to be more proactive to develop	R3. Pg10. Paragraph 4.
• The respondent tries to reduce deficits in training by encouraging psychology students to	what I do normally here, maybe I don't know about other psychologists, I allow them to come to my department and plan here and I want to motivate them they can go for higher study so we should give	R3. Pg 10- Pg11. Paragraph

do their internship in his department and further offers career planning for a future in psychology. • The respondent motivates students to further their studies in psychology	them the opportunity to do the internship here to do the attachment here in the hospital setting.	

Appendix G: Editing Letter



C.A.T. Centre
Computer Assisted Teaching

www.catcentre.yolasite.com

Dr Noleen D Loubser

52 Steele Road
Pelham
Pietermaritzburg
3201

084 831 7479

noleen.work@gmail.com

28 November 2019

Dr Assie Gildenhuys
Department of Psychology
University of Pretoria

CONFIRMATION OF EDITING

This is to confirm that I have formatted, proofread and edited the Masters dissertation of Warona Solomon, student number 12281485, titled **The work-related experiences of psychologists in public health facilities in Botswana.** I do not hold a formal editing qualification, but have been editing academic work for many years, and have devoted much of my academic career to helping develop and train academic writing skills for students.

Dr Noleen D Loubser
PhD Psychology (Witwatersrand)