Ethical Issues in Rural Nursing Practice in Botswana

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The concern for ethical principles and values is not limited to health professionals alone. However, ethical principles in nursing act as safety valves for social control to prevent professional misconduct and abuse of the rights of clients. As a result of colonial experience, developing countries like Botswana usually follow the European lead, especially examples from the UK. This article examines the ethical problems and dilemmas associated with rural nursing practice in Botswana, a developing country in sub-Saharan Africa. The major ethical problems identified are related to the distribution of and access to health resources in rural communities. It is proposed that nurses must assume responsibility in the field of access and allocation by working collaboratively with governments and other professional bodies, and that nurses as a global community must work together as a team to support each other.

Introduction

Codes of ethics of nursing practice emphasize an individual's right to autonomy, self-determinism and privacy, and the nurse's requirement to respect these rights.[1,2] As a result of colonial experience, developing countries such as Botswana usually follow the European lead,[3] especially examples from the UK. Nursing in Botswana is based on the principles of respecting persons, doing no harm, and doing good,[4] but, historically, obedience to authority has often provided the ethical basis. This usually takes the form of following institutional policies and values without question.[5] However, today, things are changing. Nurses, as members of the primary health care (PHC) team, are faced with the challenge of how to respond to ethical problems and dilemmas in an age of rapid sociocultural change, new and advanced technology, and highly scientifically-based practice. Nurses around the globe have to combine their traditional responsibilities to patients with their duties *vis-à-vis* the public as a whole. In Botswana, the universal adoption in the early 1980s of PHC as a philosophy and principle upon which the national health policies[6] were based have placed more responsibilities on nurses as agents of health care delivery. These increased responsibilities, as well as the expanded

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role of nurses, have introduced a range of ethical implications for nursing practice. Due to an acute shortage of medical doctors in Botswana, especially in the rural areas, nurses are charged with the responsibility of managing the PHC programmes and services. Akinsola and Ncube[7] have discussed the implications of this on the extended role of nurses in the rural setting in Botswana.

Discussions on ethical issues in nursing often focus on hospital settings caring for individual patients.[8] In developing African countries south of the Sahara, the current situation is even more pronounced because the vast majority of complaints about nurses come from the elite and middle class groups who live in cities, where the large secondary and tertiary health facilities are located. This view was echoed by Hulela[9] who noted that the public in Botswana often raise complaints regarding a lack of caring by nursing staff through the mass media and hospital authorities. The implication of this is that the ethical concerns confronting health service consumers and nurses in the rural areas, where the vast majority of the population resides, are often neglected. However, nurses in all settings, whether rural or urban, are faced with moral concerns, which include truth telling, paternalism, coercion, self-determination and the allocation of scarce resources.[8]

In spite of the 'economic success' story of Botswana that has been told many times over in different quarters, both abroad and at home, the question of whether and by how much the quality of life has improved has been a recurring theme. 'Official' aggregate economic statistics confirm that Botswana's economic position was transformed from one of the worst in the world at its independence in 1966 to one of the best in the 1980s and 1990s.[10] However, there are important features of the Botswana economy and society that promote poverty, such as the unequal distribution of, access to and control over assets.[11] One of the conspicuous poverty groups are members of households that subsist on agriculture.[12] Crop production is a way of life for the majority of families in rural areas in Botswana,[12] where more than 75% of the entire population live, so poverty is a major social problem. The point made here is that, in spite of the fact that Botswana has performed much better than other sub-Saharan African countries,[10] the socioeconomic situation of the vast majority of the people is not different from those of other countries. In other words, Botswana is still a typical developing sub-Saharan African country.

The promotion of PHC in developing countries is essentially a result of the 'trickle-down' approach to health development, which emphasizes centres of medical excellence in urban areas, but leaves the majority of the people who live in rural settings with little or no access to health facilities.[13] Both the social goal and the strategy of PHC underscore the fact that scientific progress generally and medical science in particular have not made a significant impact on the health status of the majority of the people in the world, especially those in developing countries. Opting for PHC in developing countries, therefore, underscores the fact that high-technology medicine has remained largely inaccessible to the poor social classes generally, particularly the rural populations. This is an issue of social inequality and social justice, because these issues are manifest in differences in health status and accessibility to health care between different sections of society, particularly between the rural and urban populations.[14] For example, in Botswana, all the tertiary and secondary health facilities are located in the cities and large settlements, while the rural or remote areas have few health posts and

mobile stops, which are, in any case, poorly staffed and equipped. This accounts for the unequal distribution of health resources between urban and rural or remote area dwellers, which, according to the World Bank[14] is an issue of social inequality and social justice. According to Maganu,[15] health status in Botswana varies from locality to locality because of the differential in levels of development. The eastern part of the country generally has better health indicators; the western districts, which are in more hostile ecological environments, have lagged behind. The infant mortality ranges from 88 per 1000 live births in one rural district in the west to 32 in one urban area in eastern Botswana.

Rural nursing practice is therefore associated with many ethical problems and dilemmas. How do rural nurses cope with the long hours of practice without relief and decide on the distribution of scarce resources? How does a single nurse serving a population of over 2000 decide on who is to be served first in case of several emergencies? How does he or she decide between working in the PHC clinic routinely or visiting clients in the community? How does he or she cope without any forms of communication facility and transport in a rural village where there are a number of terminally ill patients living several kilometres away from an urban area? This article discusses the various ethical issues that are common in rural nursing practice in Botswana and the ethical dilemmas with which these nurses have to contend.

The significance of rural nursing practice in Botswana

Since as far back as 1988 there has been widespread agreement that health development should be carried out through district or local health systems large enough to be representative and small enough to be manageable.[16] In Botswana, this view is reinforced by the current trend whereby both politics and policies are decentralized.[17] Strong and self-reliant local systems are seen as a necessary counterbalance, without which the needs of the majority who live in the rural areas seem certain to be neglected.[18] According to the World Health Organization,[19] within district or local health systems, health development is most effectively implemented through health centres that have responsibility for the maintenance of optimum health and for the care of the sick in a given area or population. Although popularized by the introduction of PHC in 1978, the idea of the health centres has long been in existence even in developing countries. One of the reasons for PHC being relevant to the needs and aspirations of developing countries is the wide variety of attempts to provide selected medical services to the general population, especially to rural communities and vulnerable groups.[20]

In Botswana, there are two levels of government: national and district. The country is divided into nine district councils and subdivided into 24 district health teams. Each district health team provides professional supervision of the basic health facilities within its catchment area. One of the features of Botswana is that there are only two settlements that are categorized as towns, Gaborone, the capital city, and Francistown; the rest are referred to as villages or rural settlements. Secondly, the rural population lives in three types of location: villages, farm settlements and cattle posts. These rural settings, which accommodate more than 75% of the population, are served mainly by PHC facilities in the form of mobile stops, health posts and clinics. Nurses are responsible for the running of

the PHC facilities, with the support of auxiliary staff. In line with the principles and philosophy of PHC, the points in favour of these facilities in the rural areas are their accessibility to local communities, their manageable size, and opportunities to make them relevant through community involvement in their management. They are also regarded as development units in the sense that, by involving community members in the management of PHC facilities, the belief is that the door is opened also to the possibility of their comanagement of other community development services and projects.[21]

However, several constraints, some of which have serious ethical implications, have been identified as militating factors against the success of these facilities. According to Kahssay,[18] PHC facilities have been sidelined by vertical programmes (i.e. those that are structured in such a way that they do not allow integration with other programmes or the pooling of resources) despite their critical position for delivering and linking a variety of services for the benefit of people's health. Kahssay[18] referred to the problem of '80/20 imbalance', in which only 20% of a nation's health resources are allocated to PHC facilities, which could provide 80% of the national health services needed. Other authors[18,22,23] emphasize that PHC is person focused, not disease focused or condition focused. Diseases and health conditions, they explain, occur in a social context and morbidity is not randomly distributed in populations; clustering is the rule, rather than the exception. Contrary to this ideal, due to an acute shortage of nurses in the PHC facilities in rural areas, nurses are forced to remain in the clinics all the time, managing the patients. The ethical issues discussed below are related to the poor availability of nurses in rural areas as reflected in the low nurse-to-population ratio, the nonavailability of communication facilities and ambulance services, and the lack of information, education and communication (IEC) services within the communities.

Ethical issues and dilemmas in rural nursing practice

In an article on rural health nursing practice in Botswana, Akinsola and Ncube[7] discussed the expanded role of the nurse, which includes: health policy formulation and implementation; programme planning, implementation and evaluation; health promotion; preventive services; and case management. By using the criteria of availability, accessibility and acceptability, this article assessed the suitability of the services being provided by rural nurses in Botswana. The authors concluded that, although these nurses are accepted and found suitable by their rural clients, due to a low nurse-to-population ratio in the rural areas, their services are not easily accessible and hence are not adequate. The major reasons associated with the low nurse-to-population ratio in rural communities in Africa are governments' inability to attract and retain adequate numbers of health personnel, especially doctors and nurses. Among others, two factors are responsible for this scenario: a lack of basic social amenities (clean water, electricity, adequate shelter, communication and transport facilities) in rural areas and a lack of incentives, such as special allowances and adequate staff quarters.[7]

The health policy of a nation or a community is its strategy for controlling and optimizing the social uses of the available medical knowledge and resources. Human values, on the other hand, are the essential guides for people

when choosing the goals, priorities and means for that strategy. Ethics is the link between health policy and human values. It examines the moral validity of the choices that must be made, seeks to resolve the conflicts that inevitably occur when making choices, and orders the choices in accordance with accepted norms.[3] The Botswana National Health Policy[6] was based on the principles of PHC. Section 3.2.2 of the philosophy of the policy states that:

> The government shall, when planning its activities, put health promotion and care, and disease prevention, among its priorities, the basic objective of which shall be access by all citizens of Botswana to essential health care, whatever their own financial resources or place of domicile, and the assurance of an equitable distribution of health resources and utilization of health services (p. 7).[6]

Considering the resource constraints, especially the acute shortage of nurses and doctors, and the unequal distribution of health resources between the urban and rural settings, is it possible for the country to meet this challenge?

For this to be discussed logically, it is important to examine the issue of nursing ethics with regard to the rights of the clients by looking at the sociocultural factors that influence health policy formulation and implementation in sub-Saharan African countries. It has been argued[24,25] that, in spite of the great influence of western and American cultures on African countries, people and the political leaders still regard the family as the institution for the care of the sick and the underprivileged. Health care models, such as the home-based care model, and ethical principles cannot work efficiently in developing countries because, even though the ideology of equal rights and state responsibilities for the underprivileged may be strongly entrenched in most developing African countries' constitutions, the law is not always strictly followed.[25] This is because, unlike in developed countries, there are few advocates of equal rights and few politicians who have a genuine interest in the constituencies that they represent.[24]

As in other African countries and partly as a result of the colonial experience of Botswana, when seen from the perspective of nursing ethics, health care in Botswana today (including rural health) and in the foreseeable future is dependent on economic policies and a political philosophy that serves the interests of the political elite, the bureaucrats and the urban privileged. This perpetuates the trickle-down effect. The situation of availability of resources is the worst in rural settings because of the '80/20 imbalance'. As already noted, PHC facilities deal with up to 80% of the country's health problems but receive as little as 20% of its health resources and attention given to health matters in policy making.[18] Ethical problems in rural health nursing in Botswana are therefore increasingly related to difficulties of distribution and access, cost and financing.

The ethical implication of the above, as in other African countries, is that rural nursing practice is constrained by policies designed to limit rather than increase access. The shortage of nurses and essential facilities such as transport and telephone services in the rural PHC centres has several ethical implications for nursing practice. According to Davis and Stark,[5] a shortage of health care professionals can lead nurses and midwives to confuse what is good for them individually and as a profession with what is good for society. Owing to an acute shortage or nonavailability of medical doctors in rural areas, adequate professional nursing experience and teamwork are important for the smooth running

of a PHC centre. Therefore, in a health post that is being managed by a young, inexperienced nurse, there is the tendency to underperform, render low-quality services, and take job-related decisions that are not guided by experience and professional guidelines. This can lead to professional misconduct and violation of nursing ethics. For example, a typical village in Botswana with a population of 2000–5000 people usually has a health post that is managed by a young, inexperienced, single-qualified nurse with the support of one or two auxiliary staff. The staff nurse is expected to perform the job of doctor, nurse, midwife, pharmacist, health educator and counsellor. He or she is expected to run the health post for 24 hours a day and there is hardly any form of supervision. Because of these circumstances, one cannot blame the nurse if he or she should fail to deliver good services because the job situation may be stressful because of severe daily hassles. The fact that one nurse may have to treat a long list of patients, attend to emergencies, requisition drugs, and carry out counselling single handed may lead to burn-out. Hence, Kahssay[18] concludes that health centres are difficult to manage in the face of inadequate teamwork, and poor technical and managerial support. Davis and Aroskar[4] explained that caring involves application of the ethical principles of respecting persons, doing no harm, and doing good. Contrary to this expectation, one of the commonest complaints of patients or clients about nurses in Botswana is that they do not treat patients with respect.[9] When confronted by authority, the only reason usually given by nurses for this behaviour is that they are experiencing burn-out or are feeling stressed by the excessive work-load.[9]

Nurses have an ethical and a social responsibility to protect and enhance human dignity, which includes the right of patients to be provided with rapid access to a clinical referral system to receive emergency care for a life-threatening health condition. This can be maintained only by an efficient communication and transport system. According to Doherty and Price,[26] referral and transport systems are vital for the functioning of primary care services in remote communities of developing countries. Rural ambulance services should be carefully planned on the basis of sound information obtained in such a way as to avoid placing an undue burden on the health system. There is, however, an acute shortage of means of both communication and transport in the health facilities in rural areas in Botswana. For example, the village adopted by the Department of Nursing Education at the University of Botswana for gaining community-based experience for the students has a population of over 2000. This village has a health post, which is staffed by a single qualified nurse, a family welfare educator and a dispensary assistant. It does not have a telephone or an ambulance service. The nearest health facility, which serves as a referral centre to the health post in the village, is about eight kilometres away. Furthermore, before the road leading to the neighbouring city was tarred recently, only a few public transport vehicles used the road leading to the village. Paradoxically, in Botswana, the introduction of community home-based care for AIDS patients has meant that the majority should be cared for in their homes. Family caregivers find it easier to care for their terminally ill relatives in their rural homes than in the cities, so the need for ambulance services to transport patients in an emergency from their homes to the hospitals located in the urban centres becomes paramount. When faced with an emergency situation, the nonavailability of ambulance services usually creates a serious dilemma for rural nurses. In such situations the only options are that the

patient's family may hire a vehicle or the patient is left without the necessary care.

One of the critically important rights of consumers of PHC services, whether in an urban or a rural setting, is access to IEC services on issues related to health promotion and preventive health behaviour. If Botswana is to tackle the problems of sanitation, ignorance of the causes of diseases, and poor sexual lifestyles (especially in relation to AIDS), community health education must not be relegated to the background. This right is entrenched in the Botswana National Health Policy. For example, section 3.2.8 of the policy document states that public health education should be promoted. Individuals and social groups should be encouraged to alter behaviour that is harmful to public or individual health and to adopt behaviour that will promote public or individual health.[6] In a study carried out by Mbuh,[27] it was shown that nurses and midwives working in PHC facilities in rural areas in Botswana, owing to staff shortages, do not have the time to provide IEC services within these communities. The study revealed that health promotion services, which constitute one of the major pillars of PHC within the communities, are often delegated to family welfare educators, who are auxiliary staff. The relegation of this important duty to nonprofessionals constitutes an ethical issue and perhaps also a dilemma for the rural nurses. Ideally, this should not be so because part of the National Health Policy (section 3.3: The rights of users of health services)[6] states that persons requiring or liable to require health treatment or care shall have the right to be so treated or cared for by appropriate means, with compassion, diligence, competence and respect. To confirm the significance of this human right, Daniel[28] observed that, in a just distribution of primary goods, there is a special place for health promotion and protection. The issue being discussed here is not peculiar to Botswana. Jinadu[29] observed that, although PHC workers in Nigeria are expected to perform a wide range of functions, evidence from the field shows that, with the exception of some voluntary organization-sponsored PHC workers, their efforts have concentrated on clinic- or health centre-based functions at the expense of community development and health promotional activities. Among others, the implications are that nonspecific, primary preventive measures, such as health promotion through IEC, which aim to bring about positive health behaviour and lifestyle changes, will be neglected.

Discussion and recommendations

The concern for ethical principles and values is not limited to health professions. A number of ethical principles are recognized in most, if not all, cultures. However, in nursing and medicine, they act as safety valves for social control, to prevent professional misconduct and abuse of the rights of patients or clients. These guidelines are centred on four basic principles of ethics: respect for persons, beneficence, nonmaleficence and justice. It is therefore incumbent on professional nurses all over the world to adhere to these agreed rules of ethical conduct. A conflict of interest or even a dilemma can occur if nurses are constrained to observe these principles because of unavoidable circumstances, as in the case of rural nurses. This may imply that the right of nurses to serve their patients or clients according to their professional beliefs and standards is also compromised.

Although the situation in Botswana is typical of sub-Saharan African countries,

having worked in two other countries in Africa, I am convinced that rural health in Botswana is in fact better than in Nigeria and Kenya. This shows the extent of the health and social problems in Africa. Sub-Saharan African countries, being member states of the United Nations and the World Health Organization (WHO) subscribe to the principles and philosophy of these world bodies with regard to human rights and ethics. Part of the constitution of the WHO[30] states that: 'The enjoyment of the highest standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic and social condition.' In addition, article 25, item 1 of the Universal Declaration of Human Rights[31] states that:

> Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

How many people in Africa today enjoy these rights? Many families still live in shacks; cholera, typhoid and guinea worm are still rampaging some communities owing to poor water sanitation; and people who live in rural areas still have to travel many kilometres to access PHC services. Nurses are also victims of these processes in all these countries, yet they are also mediators and clients' advocates.

The challenges faced by rural nurses in African countries are like the ancient idea regarding the Achilles tendon. African communities, especially rural people, have enormous health and social problems and many of them have clustered together to compound the AIDS epidemic in sub-Saharan Africa.[32] African nurses form part of that community. They are regular observers of the horrific experiences of: AIDS patients and their caregivers; the pain and anger felt by the homeless, the jobless and the people keeping themselves alive by scavenging; and the daily rituals of serious crimes committed by unemployed youths and child soldiers under the influence of hard drugs. Directly or indirectly, these are human rights issues and rural nurses are helpless to do anything about them. Nurses, as a global community, must therefore work together as a team to support each other. International boundaries must be melted to allow for the exchange of ideas and knowledge on how developed countries have addressed such problems in the past. International nursing organizations, such as the International Council of Nurses and Sigma Theta Tau International, should work with the WHO with the aim of bringing together once again health policy makers from different countries to address ethical issues in relation to rural health in an environment that allows for a frank exchange of views.

At national and local levels, nurses in African countries must strongly support the activities of their professional unions by being members of nurses' associations. Members are not expected to play the role of trade unionists, but they must support the efforts of these organizations towards achieving their noble objectives. This implies that nurses can perform an advocacy role for their patients or clients only if they are strong and united. They have an ethical and social responsibility to use professional and political organizations as a means of demanding fair access to basic health services for rural inhabitants. As professionals, they should assume responsibility in the fields of access and allocation

by working collaboratively with governments and other health professionals such as doctors, and paramedics. Nursing professional associations must develop strategies to empower their members through tertiary and continuing educational programmes so that nurses can rise to top management positions where they can influence health and social policies to benefit everybody, including rural dwellers. This calls for the development of university distance learning programmes to prevent the exodus of nurses who are interested in further education.

Recently, aggressive recruitment of nurses carried out by some nursing agencies in industrialized countries, notably in the UK and the USA, has worsened the situation of nurse manpower in the southern African region. In countries such as Botswana, local nurses are now emigrating to the UK in large numbers, thereby worsening an already bad situation, especially in the rural areas. One nation's health care gain should not be another nation's drain,[33] for it may be interpreted to mean that industrialized countries are not sensitive to the human rights needs of rural African people whose health concerns have already been badly compromised owing to a low nurse-to-population ratio. This does not imply that nurses should not be allowed to exercise their right to free movement or to choose what is good for them but, in the interests of societal health, political and socioeconomic solutions should be sought to solve the problem of the brain drain in African countries.

The challenges posed to Government by ethical issues and other problems are many. Primary health facilities should be able to respond dynamically to whatever health problems arise in their catchment areas. This implies that they must be equipped and staffed to provide a wide range of health services and preventive activities (both in the clinics and in the rural communities) and to tackle the emerging health agenda of lifestyle and socially related problems, such as the control of HIV transmission. The major challenge from this is that both the national and district governments must play a leading role in creating a favourable environment for PHC facilities. In order to remove 'the 80/20 imbalance', conscious efforts must be made to shift resources towards the health facilities in the rural communities.[18]

If proper attention is not paid to the health resource needs of the rural communities, who form the majority of the population in Botswana, the rights of the people according to the National Health Policy and the international conventions on human rights will continue to be violated. This will invariably continue to render rural nursing services in Botswana inaccessible to their target populations.

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