# REFLECTIONS ON NURSING EDUCATION ISSUES IN BOTSWANA

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**Abstract**

Changes in nursing global market environments such as shortage of nursing personnel and increasing diversity of students and health care providers demand that nursing education be aligned with new developments if it is to continue being relevant. In this paper, the authors make a reflection on the challenges facing nursing education in Botswana in the 21st century and suggest strategies for moving forward. The challenges explored include nursing personnel shortage, the increasing diversity of nursing students, increasing diversity of the health human resources in the country, and the proposed merger of the health professions' regulatory councils. Among the strategies for moving forward, it is obvious that working in silos is no longer a viable strategy for health professionals and that collaboration should start right from training. Although education is the main focus of the paper, practice cannot be ignored because teaching prepares students for practice.

**Keywords:**

Nursing education; unionization; nursing global market; Botswana

## 1.0 Introduction

Challenges in nursing's global market environments such as shortage of nursing personnel and the increasing diversity of students and health care providers demand that nursing education be aligned with new developments if it is to continue being relevant. Although the challenges experienced in Botswana may be similar to those in the global environment, the unique context of country demands that they be given special attention. It is therefore important to reflect on specific developments that have had or are likely to have influence on nursing education in the country. It is only then that appropriate responses can be designed to address challenges and to exploit any opportunities.

## 2.0 Methods

The authors collaboratively performed desk review of the literature using key words such as development of nursing education and Botswana; challenges of nursing education and Botswana; nursing education and 21st century; and global challenges and nursing education. Data bases searched were EBSCO HOST, Botswana Government Websites, GOOGLE SCHOLAR, PUBMED, and CINAHL. In addition, the authors searched by hand and examined grey literature and reports especially related to the nursing education in Botswana. Examples of sources were students list disaggregated by gender and the authors' teaching portfolios. Lastly, authors also made inferences from their personal experiences as graduates of Botswana nursing education programmes and as nurse educators in Botswana but also as graduates of nursing education at regional and international levels. The authors discussed what was garnered from various sources and came up with the major ideas for the paper.

In this paper, the authors make a reflection on the challenges facing nursing education in Botswana for the 21st century. The paper seeks to stimulate discussion on the readiness of nursing education in Botswana for the 21st Century and on new directions that are necessary for moving forward. The challenges explored include nursing personnel shortage, the increasing diversity of nursing students, increasing diversity of the health human resources in the country, and the proposed merger of the health professions' regulatory councils. Some strategies that may hold promise for moving forward are suggested. In order to provide a context for examining the status quo, the paper starts with an overview of the country's nursing education and how it has evolved to where it currently stands.

## 3.0 Overview of Nursing Education in Botswana

Formalized nursing education in Botswana can be traced to the missionary era in the 1920s when the few mission hospitals and their expatriate nurses who had trained in their own countries saw a need to train local nurses to provide care to patients. After gaining independence in 1966, Botswana established health training institutions which offered certificate and diploma nursing programs training practical nurses and professional nurses, respectively; with some of the latter proceeding to an additional diploma in midwifery (Selelô-Kupe, 1993). Later on, a few faith-based hospitals in the country also established schools offering nursing certificates and diplomas. Following the government's aggressive development plan biased toward rural areas in the 1970s, and the Primary Health Care movement of 1978, the government provided additional diploma for professional nurses; the first of those being family nurse practitioner, which was followed by others such as community health nursing, nurse anesthesia, and psychiatric-mental health nursing (Klopper & Uys, 2013). In response to concerns about the limitations of the certificate programs, the qualification was later phased out and its graduates were up-graded to professional nurses; a process that was completed in 2003 (Ministry of Finance and Development Planning, 2003).

The nursing degree program at the University of Botswana started in 1978 with the aim of training nurse educators to teach in the diploma and certificate programs. In the absence of any health oriented faculty, the Faculty of Education was found to be the most appropriate home for a program for nurse educators who exited with a Bachelor of Education (Nursing) Degree. Nursing core was therefore taken along with education (curriculum development and evaluation, teaching and teaching evaluation) (Department of Nursing Education Handbook 2007-2008). In 1985, the program started enrolling students from clinical services whose focus was leadership and management. However, because graduates were

exiting with a Bachelor of Education (Nursing) Degree, they still needed some education content. For the management and leadership stream, however, the focus was on life-long learning; and graduates were expected to offer life-long education to nurses in the workplace, support students' clinical learning, and provide leadership in health education programs for communities (Personal Reflection by Author One).

In addition to local students who were the majority, the Bachelor of Education (Nursing) degree attracted nurses from countries such as Malawi, Kenya, Namibia, South Africa, Lesotho, Swaziland, and Zimbabwe (Department of Nursing Education Handbook 2007-2008). In 1996, the first masters' degree students were enrolled; and in 2000, with its science foundation strengthened, the Bachelor of Education (Nursing) Degree program converted to Bachelor of Nursing Science(BNS) and started enrolling pre-service students along with those upgrading their diploma to a degree (Department of Nursing Education Handbook 2007-2008). Following the establishment of the faculty of health sciences at the university in 2007, nursing program re-located from education to the health sciences.

Currently, nursing education in Botswana is primarily provided by the government in six institutes of health sciences that offer diploma in basic nursing and post basic diploma in community health nursing, psychiatric-mental health nursing, midwifery, and family nurse practitioner. Two faith-based hospitals also offer diploma programs (Ministry of Health, 2012). In addition to the undergraduate degree program, the University of Botswana offers masters' degrees in midwifery, community health nursing, psychiatric-mental health nursing, family nurse practitioner, pediatric nursing, and adult health nursing. Botswana nurses also study in countries such as South Africa, Canada, Australia, United Kingdom, and the USA. South Africa provides both undergraduate and post-graduate degrees while universities overseas mainly provide post-graduate degrees. The ratio of nurses to population in Botswana was reported as 24.2 per 10,000 people in 2004 (United Nations in Botswana, 2007).

## 4.0 Challenges for Nursing Education in Botswana

The conditions and status of nursing education and practice in Botswana are not very different from those in many parts of the world, particularly those articulated by Pearson and Peels (2001) that include poor salaries and general working conditions, high workloads owning to low numbers of available pool of nurses, limited opportunities for further education, inadequate material resources such as infrastructure, equipment and supplies, domination by medicine, and lack of recognition of nursing's contribution to the health of the society. However, only selected challenges that are seen to be salient for Botswana are addressed in the paper and these cover shortage of resources, diversification of the pool of students, diversification of the human resources for health, and the proposed merger for the health care regulatory councils.

## 5.0 Shortage of Resources

*Government's curtailment of funding continuing education for practicing nurse*

For a long time, the Ministry of Health remained the major funding agency for in-service nursing education and the primary employer for nurse graduates. This resulted in long queue of nurses waiting for their turn to be funded for further education. Unfortunately, as one would be waiting for his/her turn, the age of retirement would be drawing closer, such that following graduation, some would only serve a few

years before they retired. The advantage of that order was that national needs and priorities determined which specialized training areas to invest in as well as the modalities of graduates' deployment. Government funded students had to sign an agreement with the government that they would, upon graduation, serve the government for a specified period after which they could pursue their personal aspirations.

As budgets began to shrink, the government reduced the scholarships for in-service education for nurses. This meant that nurses would increasingly fund their in-service education. The advantage of this order is that nurses enjoy the flexibility of pursuing their personal interest; they can get developed when they are still young such that they will have ample time to use what they have learned to the benefit of the nation. Nurses unconstrained by the conditions associated with government funded education can easily cross the borders to get exposed to other health care systems and to get the economic benefits of working in more developed economies. If they do come back home, they contribute to improvement by bringing another perspective to the health system. Unfortunately, the impact of the vacuum created by nurses who temporarily leave the country for a few years often clouds the opportunities embedded in the international experience.

While the pursuit of personal interests has some benefits to both an individual nurse and the country, it may compromise the needs of the population as for instance, the number of nurses completing training at a given time cannot help one to accurately predict how many of those graduates will be joining the public service. Required skill-mix is compromised if no one gets attracted to a given field of nursing.

*Lack of formalized preceptorship in clinical learning*

One must appreciate the great strides that have been made toward improving nursing education in Botswana as reported earlier on in this paper. However, there remains critical shortage of staff in both classroom and clinical learning; with the latter being worsened by the absence of a formalized clinical preceptorship system. Applied to nursing education, a preceptor is an experienced clinician who, in addition to service responsibilities, facilitates and evaluates learning, serves as a role model, and fosters the development of clinical skills and confidence as well as socializes students to the nursing roles through a direct involvement with them in the clinical area over a predetermined time period (Hyrkärs & Shoemaker, 2007; Mills, Francis & Bonner, 2005; Ryan-Nicholas, 2004). Edmond (2001) noted that given the right tools, a clinical nurse mentor is best placed to teach complex work management and coordination skills through role modelling and discussion as she/he has intimate knowledge of the context and immediate peer group support. Resources constraints have been the limiting factor in institutionalization of full preceptorship. Clinical teaching/learning workshops for both clinicians and educators have been sporadic, usually driven by external funding opportunities.

*Limited diversity of clinical settings and inadequate clinical space*

Owing to the shortage of resources, students' clinical placement is often limited to major towns and urban villages where training institutions are concentrated. Overcrowding of students in such facilities is therefore not uncommon; sometimes with the same patients being recycled for skill rehearsals and demonstrations. The challenge of clinical learning is even more felt by graduate students who rarely find specialist clinicians in their area of study. It could be difficult to sell nursing as a career with good prospects to the 21$^{st}$ century generation if education programs fail to provide students with well-resourced learning

experiences such as diverse faculty and supervised clinical learning. The same argument could be advanced for sub-standard working conditions.

*Aftermath of the HIV and AIDS pandemic*

The HIV pandemic has had its own contribution to the shortage of staff, particularly in clinical areas. A 2006 report showed that between 1997 and 2001, the number of nurses in Botswana declined from 26.3 to 23.8 per 10,000 population (Teng-Zeng, 2006). Being under-staffed, the clinicians in public health facilities have high workloads that make it difficult for them to devote meaningful time to coaching students. This scenario occurs along with shortage of nurse educators. In classroom learning, graduate students have expressed concern about lack of diversity in faculty whereby they might have all specialty courses in a program offered by one person (Sabone, 2011).

## 6.0 Diversification of the Pool of Nursing Students

The current in-house post-graduate programs are often unappealing to the present generation student, who is frequently full-time employed, self-funded, and a family man or woman. There is increasing need for distance education and on-line delivery as employed persons may find it difficult to re-locate to educational institutions which are usually located in large cities and towns. Frequently, family life becomes disrupted when one parent moves to another geographical area, often being compelled to re-locate all or some of the children from one school to another. In addition, semester-long course offering is proving costly for students who often interrupt their program of study to attend to the demands of work and family.

There has been increased number of males in a profession that was for a long time dominated by females. The percentage of male to female students often reaches as high as 40% in the bachelor of nursing science program. However, the nomenclatures in nursing positions still suggest that nursing is a field exclusive to women. For instance, such nomenclatures as matron and midwife may deter males from aspiring to those positions or specializations.

## 7.0 Diversification of Human Resource for Health

Whereas nursing has enjoyed being the only health profession at the University of Botswana, it now competes for attention with many health professions such as medicine, public health, and allied health professions. This is a challenge in that nurses must be able to negotiate for resources so that they have an equitable share of the cake. However, another side of the establishment of other health disciplines at the university is that such developments may be an opportunity for nursing. Nurse graduates can establish networks and team up with graduates of other health professions to establish private agencies or to partner in projects such as research and consultancies.

Particularly because of the human resources challenges brought about by HIV and AIDS, there has been a proliferation of unlicensed cadres in the health care delivery system as well as institutions that train such cadres. One now finds lay counselors and other health care providers that nurses need to work with. Nurses are therefore challenged to maintain the credibility as the most cost-effective and accessible health care providers in the country. Elsewhere, it has been observed that the proliferation of unlicensed cadres

has burdened nurses with supervisory responsibilities (Bearwood, 1999). Even before the emergence of new cadres of health workers that was mainly a response to the HIV and AIDS pandemic, nurses in Botswana have traditionally filled in for other health disciplines that the country did not have in adequate numbers, especially in rural and remote areas. Slowly, other disciplines have taken up their positions in the health care delivery system. The country now has significant numbers of social workers, pharmacy personnel, physiotherapists, dieticians, and dental therapists posted to a wider geographical area. Nurses are continuously challenged to align their work with that of emerging disciplines.

## 8.0 Proposed Merger for Nursing and Health Professionals Regulatory Councils

One of the challenges in nursing which may have implications for education as it may need a re-definition of how nursing is practiced in the country is the on-going discussion on the merger of the health professions regulatory councils. Currently, there are only two health professions regulatory councils in the country, the Nurses and Midwives Council of Botswana (NMCB) that regulates nursing and midwifery and the Botswana Health Professions Council (BHPC) that regulates more than twenty other regulated professions including medicine, dentistry, and pharmacy. The motivation for the merger has not been clear to nursing leaders. As such, one cannot foresee how such a merger is likely to affect nursing practice and education in the country. While health care reforms all over the world are usually meant to improve the status quo or to address an existing problem in the system, they may have implications that go beyond what was anticipated and sometimes even bring about a worse state of affairs than what was thought to be problematic. Results of these re-structuring processes have been mixed with some, such as increased public's control over professional practice being welcome while others such as the increasing number of people receiving care from unregulated providers being unwelcome (Bearwood, 1999).

## 9.0 Recommendations for a Way Forward

The recommendations presented here should provoke a springboard for discussions on the directions for moving forward. They cover a little about the clinical service and a lot about curriculum reforms, which should not be a surprise as the focus of the paper is education.

## 10.0 Recommendations for Clinical Services

Like shortage of nurse educators, the shortage of nurse clinicians has a direct effect on students' learning, particularly clinical learning. A seasoned clinician, especially if motivated, could be a good resource for both students and teachers. Re-employing retired nurses could be one option as the government is already doing, albeit only to a limited extent. Especially with the migration of nurses to greener pastures, citizens of a ripe age may be more prepared to settle in their country and serve their people than the young generations who may find the local working conditions too hostile to be habitable. However, the economic implications of re-employment of pensioners must be researched so that the economic returns of paying pension and salary to one person is carefully examined. In addition, a computerized system of the human resources, not only for the health force, but for the entire country may help in determining personnel placement/posting and can guide family-friendly personnel posting.

Being a member to the International Council of Nurses (ICN) and other international bodies is an opportunity for Botswana nurses that must be tapped when uncertainty arises. Such issues as the proposed

merger of regulatory councils may not be adequately addressed through the sole effort of local nurses. Consultation with ICN could help Botswana learn from the experiences of others. A thorough analysis of the situation with extensive and intensive stakeholder participation is therefore necessary before such a change can be introduced. A clear layout of the problem, its contributing factors as well as a consideration of alternative solutions together with the risks and benefits of each could create an opportunity for a dialogue and consensus on the best solution.

Nurses who strive to attain graduate education through own efforts need to be commended and supported by fellow nurses because high education is a gateway to a higher status of nursing. Higher education will not only improve the quality of care but could also get nurses into policy influencing positions where they can better articulate the value of nursing (Long, 2004; Wynd, 2003). The presence of a significant number of nurses with graduate education, coupled with a strong support or membership to professional body that amplifies its voice through unionization, could build a strong case for the recognition of nurses and could attract young people to nursing.

The challenges related to the increasing diversification of health care providers demand that nurses re-define their niche in the health care arena and that they welcome the new workers, and develop meaningful and professional relationships with them that will ultimately benefit the society at large. They need to monitor the increasing population of unlicensed assistive personnel in the country and how that impacts on the work load for nurses and survival of the discipline of nursing so that they can participate in nurturing a healthy environment for the co-existence of all players in the health care delivery system. Even as they negotiate the space with new providers, nurses still need to be responsive to the needs of populations that remain unreached by any other cadre of health professionals but nurses. This requires that the government recognizes the diverse scope of practice for nurses when determining their compensation. Nurses must equally pay attention to the challenges of their work in designing curricula and in developing practice regulations including their scope of practice. They need to fully engage one another in dialogues that move nursing forward.

## 11.0 Recommendations for Education

*The need for entrepreneurship competencies for nurse graduates*

The fragility of the economic environment in the country, particularly the over-reliance on the mining sector as the primary source of income for the country, has prompted the government to encourage development of entrepreneurship skills among the youth to break the tradition of graduates who are job seekers and to cultivate a vision of graduates as self-employers and small business owners. The same spirit needs to be cultivated in nursing students. In fact the importance of entrepreneurial skills in education is not a concern that is unique to Botswana. Moore (2002) noted that advocacy for launching of own business on the part of new graduates in the USA was a response to the uncertainty of the economy. Levenburg et al. (2006) challenged business schools to look beyond their boundaries and incorporate in their programs, entrepreneurship education for students in non-business disciplines such as nursing. This would mean, among other things, that curricula are flexible such that exclusion criteria such as course pre-requisites are removed to open the door to students from across disciplines.

Nursing education in Botswana is yet to clearly articulate the concept of entrepreneurship in its curricula. Entrepreneurship needs a special attention considering the welfare culture of Botswana's early post-independence period and the market environment that is lacking in models of nurse entrepreneurs and

that has a small population base. There is a need that government supports independent practice for nurses through creation and enforcement of relevant legislation so that independent practice becomes one way of increasing nurses' economic and professional autonomy.

*Re-orientation of Curriculum*

Le Sorti et al. (1999) recommended an approach to learning that fosters responsibility, creativity and innovation, and in which faculty play the role of reviewing the students' progress, providing moral support and encouragement, and providing direction to information resources. One needs to see in assignments, projects that present the learner with an opportunity to think beyond own specialty area, beyond the discipline of nursing, and beyond a specific problem that a client may be presenting with. That kind of learning experience helps the student to see the interrelationship of different aspects of a person's life and to appreciate the holistic being of a person as well as the inter-phase of nursing and other disciplines (Radzyminski, 2005).

Although nursing students in Botswana engage in collaborative learning in community settings, much still needs to be done in reducing emphasis on the lecturing approach to learning and teaching. Adopting students' self-directed learning such as problem-based learning will require that resources such as staffing and space be put in place. The embracement of problem based learning could present an opportunity for the transformation of learning for Botswana's 21st century nurse. More importantly, the faculty's mindset needs to be prepared because old traditions may take long to die out. Problem-based learning requires that faculty trusts that students are a powerful learning resource and refrains from transmitting knowledge to allow the students to navigate the waters.

Getting ready for the 21st century requires curricula transformation that considers the nature of the students attracted to the nursing programs, critical content areas to be covered, and methods of program delivery. Programs must have flexile modes of delivery so that they can accommodate non-traditional nursing students such as those who need to balance work, school, and family responsibilities (Kevern & Webb, 2003). Indeed locally based programs have lost potential students to those universities that have diversified through modalities such as on-line and distance learning. However, caution must be exercised to make sure that the appeal of convenient modalities such as distance education does not lead to compromised quality as often unchecked students' recruitment targets may result in the students-staff-ratios that fail to provide students with meaningful faculty-student interaction and compromised quality of learning.

Nursing programs can be accommodating and welcoming to increasing male students through availing such resources as male nurse clinicians who can spend meaningful time with students. It has been observed that male nurses often feel left out, missing a male nurse role model in their professional socialization, isolated and suppressed for fear of being ridiculed in a female dominated profession, or stereotypically treated on gendered lines (Scott, 2007).

Programs at all levels must as much as they focus on the substantive content of nursing, infuse content critical to emerging local and global issues. For instance, they must demonstrate responsiveness to the aging population through incorporating older adult content in undergraduate, graduate, and continuing education programs; with rotation in older adult units being a requirement for all masters' degree programs

(Kovner, Mezey & Harrington, 2002). Content in areas as public policy, integrated information technologies, resources allocation, communication, and organizational politics has been argued to be critical for 21st century nurses (Radzyminski, 2005).

As the teaching and learning process evolves, re-orientation of the teacher is important. It is important that teachers create a clinical learning atmosphere in which students feel safe and comfortable. Del Prato, Bankert, Grust, and Joseph (2011) recommended that teachers de-emphasize evaluation and strive to provide a supportive learning environment in order to minimize anxiety that is common in clinical learning. A structured orientation of students to what they can expect in clinical learning could ease their anxieties and enhance their openness to discovery, creativity, and problem solving (Del Prato, Bankert, Grust, & Joseph, 2011). If the teacher approaches the learner as someone who brings something to the teaching-learning encounter, the learner is likely to carry that attitude to an encounter with clients, respecting their world views and valuing the abundance of experiences that they bring to the care encounter.

*Inter-professional education*

Malloch and Porter-O'Grady (2006) argued that the traditional non-aligned and siloed practice must be replaced by recognition of the value of the contributions that every discipline makes to client outcomes. With necessary care being taken to ensure that participating disciplines align their learning goals in a way that does not compromise their core values and roles, interdisciplinary education provides an opportunity for professionals to compare care practices and enhances understanding of the roles and responsibilities of other disciplines (Mpofu, Daniels, Adonis, & Karuguti, 2014).

Inter-professional education is one area of the Botswana nursing education system that needs to be strengthened. Multidisciplinary problem-based learning could provide an opportunity for students in each discipline to identify own niche and to have a practical experience of interdisciplinary engagement. Especially that medical education is relatively new in Botswana, nurses and doctors have in the past, only met at the practice level. There is need for the two to work closer together and to exchange values that drive care outcomes. Familiarization to one another's field at a point where prospective nurses and doctors are getting socialized to their respective professions could ease their collaboration in practice for better coordinated, cost effective, and quality client care (Heller, Oros, & Durney-Crowley, 2000).

## 12.0 Recommendations for Health Policy

*Collaboration of modern and traditional health care systems*

Botswana has a traditional health system that pre-dates the western or modern health care system, but that has remained under-developed, unregulated and undocumented; a situation that deprives the health system of an important resource of the wisdom that has been accumulated over a long time. Although the country's health policy encourages the two systems to work together, any meaningful collaboration is yet to be realized. Interacting with and acting within a system that is unregulated and for which there is inadequate documented evidence of how it works may make people uncomfortable both to engage in and to sell the system to others.

Nurses need to appreciate the clients' side-by-side use of the traditional and the modern health care systems and therefore respect that reality in working with clients. Because the majority of nurses in Botswana are locals, they may be more familiar with the traditional health care system than other health

professionals and can therefore be instrumental in proving stewardship in bringing the two systems closer together. There is need for research on bringing the two systems closer together; and such research would be best if it is multi-disciplinary, conducted with the co-participation of traditional and modern health care practitioners. In that way, the resultant knowledge would be a shared reality and therefore more likely to earn the respect of multiple stakeholders and to make impact on the health care system. Students must also be encouraged to research on the traditional health care system through modalities such as inviting them to collaborative research teams. Research could also provide ideas toward regulation of the traditional health care system.

Not only must nurse educators recognize and appreciate the traditional health care practice but they should also recognize the indigenous ways of knowing in general. Education must balance vocational training and professional education such that graduates will as much as they use technical expertise in direct care, think beyond the 'here and now' and appreciate as well as respond to the interrelatedness of care and broader social issues. Merriam (2008) argued that educators in the west have come to appreciate the epistemological systems of non-western cultures such as mind-body, emotion-reason, and individual-group connectedness. Like other Africans, Batswana (*natives of Botswana*) have long used storytelling, music, and poetry to educate, to socialize and to inform. The rich oral tradition can be incorporated in professional education to enable graduates to better communicate with communities and to enhance accommodation of the client's perspective in health care decision making.

Nursing students need to be exposed to structures such as the traditional governance systems and older adults for inter-generational exchange of worldviews, experiences, and meanings. Botswana chiefs (traditional leaders) have played an active part in influencing nursing legislation and in advocating for quality health and nursing care for communities (Mogobe & Ncube, 2005). There has been a small scale effort to involve chiefs in an undergraduate nursing clinical course offering in Botswana whereby students have been invited to participate in addressing family and community interpersonal relationship matters brought to the chief for arbitration. Such efforts need to be formalized and up-scaled for students' meaningful benefit.

*Optimization of the unionization opportunity*

Unionization has extended from blue collar occupations to professions such as medicine and nursing because it has been found to be effective in getting the voices of professionals across. For instance, in the US, unionization of nursing was mainly motivated by limited career opportunities and lack of professional autonomy and has been described as a force for positive change and a better quality of care (Breda, 2007). In the Netherlands, the strong unionization of nurses, who are said to enjoy recognition as professional counterparts of the medical staff, has been linked to the fact that nurses are key personnel in the health sector (Hjalager, Lassen, & Bild, 2009). In Botswana, organized structures of the profession have spoken out about the conditions of service for nurses and the recognition of their selfless contribution to the improvement of the lives of populations. However, the voice of nurses still falls short of being heard.

The relatively recent unionization of the nurses' and midwives' professional association in Botswana is therefore an opportunity that holds promise for changing the status quo, albeit needing a little time and some patience. For optimization of the unionization opportunity, however, nurses need to study the movement so that they can understand it and use it effectively. Areas that have stimulated debates surrounding unionization have mainly centered on whether there is congruence between professional

behavior and strikes and boycotts that are commonly associated with labor unions. However, in his study on the compatibility between unionization and professionalism, Rabban (1991) revealed that, in essence, professionalism and unionization are not incompatible. It was however noted that the terms of agreements differed from one agreement to the other and that agreements that replaced independent professional councils with direct union representation have tended to play down professional values (Rabban, 1991).

As they unionize, Botswana nurses must therefore carefully study the terms of agreement and be satisfied that professional values are well incorporated. Such strategies as aligning nursing legislation to the culture of unionization and emphasis on quality of care and social justice and how those are related to nurses' conditions of service have been recommended (Duffy, 2010). Bearwood and Kainer (2013) argued that nursing as a profession is risk-ridden and that though nurses may speak of professional autonomy, in reality, they have little control over the conditions within which nursing is practiced, and that in pursuit of the duty to care, nurses often sacrifice their personal health for the employer's gains. Keeping abreast with the movements of both professionalism and unionization in both research and practice is important as it can help students and practitioners to understand that like everything else, such phenomena will only remain relevant if they keep evolving.

Learning from their study of the collaboration between management and union's shop stewards in Denmark, Hjalager, Lassen, and Bild (2009) advised that shop stewards be carefully selected and left to serve over a long time in order to build experiential power rather than being frequently replaced. Another consideration for benchmarking could be formation of coalitions depending on what is at stake. Coalition-building can be a leverage point when a group of workers have a common need that they wish to present to the employer or public (Duffy, 2010). Nurses can benefit from participating in coalitions that include workers with more bargaining power (Duffy).

It is also important for unionized nurses to take interest in critics of the unionization movement because that will help them to act on tendencies that may threaten the welfare of both the public and nurses. For instance, defending professionalism against unionization, Bryan-Brown and Dracup (2003) argued that trade union often demand staffing ratios that are unrealistic considering the prevailing shortage of human resources. Similarly, Coughlin (2001) argued that it is unprofessional for nurses under the union to wear buttons communicating the message that nurses demand safe staffing because that could be anxiety provoking for patients and families. Such stories must sensitize nurses to the sensitivity of some matters and the need to work with unions to come up with safer practices.

Among the areas that may benefit from unionization is lobbying for the recognition of nurses' contribution to the nations' health. The low recognition of nursing is in part, a result of the historical development of nursing as a gendered profession in a patriarchal system of a class-based health care system (Breda, 1997). Through their union, nurses must continue to assert their value through strategies such as research and dialoguing with legislators. The political system must be seen to recognize the differences in levels of education and to deploy graduates accordingly. Deploying graduates in areas completely divorced from their programs of study disempowers them and reaps them of the opportunity to use what they have learned to influence policy or to advocate for improvement in the conditions of service in their areas of specialization. When graduates are underutilized, the quality of care is compromised and the society fails to accord nursing the recognition that it deserves. However, it would be self-defeating on their part if nurses

do not make an effort to earn themselves respect and appreciation by the way they discharge their mission. Among other things, others must see nurses valuing one another.

## 13.0 Conclusion

Nursing education in Botswana is faced with a number of challenges that include, among others, shortage of human resources in both classroom and clinical teaching. However, along with the challenges, there are some situations that can be seen as opportunities that must be exploited and that may be a leverage point in the face of the hard times. Although to a large extent, the challenges presented in this paper are not very different from those faced by nursing education worldwide, the HIV and AIDS impact, a post-independence welfare background/history, and a small population base are some of the factors that make the experience of Botswana unique. Among the strategies for moving forward, it is obvious that working in silos is no longer a viable strategy for health professionals and that collaboration should start right from training.

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