Botswana Health Policies and Alternative Health Services: Implications for Holistic Health Services Provision

Amon Marwiro and Lovemore Togarasei

Abstract

This article reviews the policies and guidelines that govern medical practice in Botswana with the aim of establishing implications for holistic health services provision in the country. Based on both review of literature and fieldwork findings from health experts, the article established that although many Batswana make use of alternative health systems, there are no policies to regulate the practice of alternative medicine and, especially, to allow collaboration of both medical and alternative health practitioners. The article recommends that Botswana should establish policies and guidelines to govern the practice of alternative health systems guided by World Health Organisation recommendations.

KEY WORDS: Botswana, Health, Policies, Regulations, Traditional Healers, Alternative Health Practitioners

Introduction

In an environment where several options for health and healing services are available, like in Botswana, health care seeking or health provision are visible behaviours which reflect deep rooted cultural, social and religious beliefs. As much as behaviour is moulded by religious, social and cultural beliefs among many other factors (Latunji and Akimenyi 2018),[1] it is imperative to understand the regulatory framework within which health care is sought and provided, the scope that was provided to the board providing oversight to the provision of health care and the resources that are available as these invariably influence health care seeking and provision. Togarasei, Mmolai and Kealotswe (2016) observed that despite widespread usage of alternative health systems in Botswana, the health regulatory framework did not accommodate alternative health systems. It is on this basis that the regulations, policies and guidelines providing health care in Botswana were reviewed as part of the study on the impact of religious beliefs on health seeking and health provision behaviours among Batswana. It is anticipated that the provisions of the regulatory

[1] Latunji, O.O. and Akimenyi, O.O. (2018), "Factors influencing health-seeking behaviour among civil servants in Ibadan, Nigeria," *Annals of Ibadan Postgraduate Medicine* 16(1): pp.52-60.

framework, when analysed together with health care seeking and provision behaviours, recommendations on improvement of health through changes in theological and medical education can foster synergistic collaboration among faith, traditional and biomedical health care providers.

In 1948, WHO defined health as, "a state of complete physical, mental and social well-being and not just the absence of disease or infirmity" (WHO, 1948). This definition has continued to guide nations in wholistic health provision. Globally, the World Health Organization (WHO) offers guidance to member countries on how health is provided. Member countries in turn adapt the guidance to suit their local contexts. WHO advocates for health to be treated as a human right, which gives governments the responsibility to create an environment where culturally acceptable health care is available, safe, effective and affordable. Botswana is one of the WHO member countries that follow the guidance of WHO in the provision of health care.

In Botswana, the constitution is the highest law of the land and govern the development of all the other regulatory guiding instruments. In addition to guiding the selection of the head of state, establishment of the cabinet and all the other governing bodies such as the parliament and judiciary and their responsibilities, the constitution stipulates the rights of the citizens inclusive of health. The government department charged with the responsibility of providing overall oversight and delivery of health services for Batswana is called the Ministry of Health and Wellness. It is charged with the formulation of regulations, policies, standards, norms and guidelines for health provision. In addition, the Ministry of Health and Wellness also provides health services through a network of health facilities and management structures (Botswana National Health Policy, 2011). In this article, we therefore review some of the acts, regulations, guidelines and policies that guide the provision of health care in Botswana. Besides making a review of the policies, this article also presents findings on what the effects of these policies are to holistic health care in Botswana. Data for the article was collected through desk review and fieldwork as detailed in the next section that outlines the methodology that was used for the study from which data for this article is drawn.

Methodology

This article is drawn from a larger study that was conducted between 2018 and 2020 in Botswana. The aim of this study was to establish how religious beliefs impact health seeking and health provision behaviours among Batswana and, from the findings, to propose review of theological, medical and health education for the purposes of promoting holistic health through the integration of medical, traditional and faith healing. The study adopted a mixed methods approach. Beginning with detailed review of existing literature, it collected quantitative data using questionnaires and qualitative data through focus group discussions and individual in-depth interviews. The quantitative and qualitative tools sought to collect information from four different groups of people (medical health practitioners, traditional healers, faith healers and health seekers) on their views on causes of illness, medication, collaboration of alternative health systems, organ and blood donation and curriculum issues in religion and health. Data for this article is, however, limited to views on health policies and health policies formulation as supplied by participants. Participants who provided data on this aspect of the study included government ministers, hospital superintendents, directors in different departments of the Ministry of Health and Wellness and other members of the District Health Management

Teams. The participants were drawn from 8 different geographical areas representing the north - south and the rural - urban divides of Botswana. All necessary steps were taken to protect the identities of the participants. Thus, for example, in presentation of data, we do not identify the respondents by name but by codes (e.g., MAP001) that each of the respondents was given during data collection.

Botswana Regulations, Policies and Guidelines on Health Care

The Public Health Act (1981)

Promulgated by the parliament according to the provisions of the Botswana Constitution, the Public Health Act guides the Ministry of Health and Wellness on actions that need to be taken to prevent the spread of infectious diseases. The act gives the Ministry the power to institute control measures. Armed with the Public Health Act, the Ministry of Health and Wellness can enforce treatment, immunization, inspections, destruction of potential sources of infection even in private properties and even against one's cultural, religious or health and healing beliefs. According to the Public Health Act, the health of the population supersedes the rights of individuals. This standpoint is well aligned to the WHO's International Health Regulations of 2005.

The Public Health Act also stipulates the role of the Ministry of Health and Wellness as to educate, communicate and create awareness on diseases that have the potential for spread, the control measures and the treatments that are available. The interventions stipulated in the Public Health Act are proven biomedical interventions with effectiveness that has been proven scientifically. The Act does not recognize the role of faith healers, traditional medicine or other alternative treatment and healing modalities in the prevention and control of infectious diseases. The basis for the interventions is mainly motivated by the biomedical evidence of disease causation and prevention principles.

The Medical, Dental and Pharmacy Act (2001)

The Act stipulates the establishment of the Health Professions Council and guides its operations. The mandate of the Council is to license and monitor the practice of doctors, dental, pharmacy and allied health practitioners. The Act also guides the registration and licensing of practice. The prerequisite for licensing is based on the recognized training that is based on biomedical training. There is no provision for registration of practitioners of alternative health care.

The Nurses and Midwives Act (1986)

The Nurses and Midwives Act guides the practice and ethical conduct of nurses and midwives as providers of health in Botswana. It stipulates the formation of the Nurses and Midwives Council and gives the council the mandate of licensing, maintaining registration and set the code of contact and ethical and nursing practice standards including the disciplinary procedures and deregistration in case of misconduct. It also defines the scope of nursing practice. The act does not cover traditional midwives.

The National Health Policy (2011)

The National Health Policy, which affirms health as a right, acknowledges the broader definition of the determinants of health which include the environment where people grow, live, work and age as key influencers of the health of the population. The Policy stipulates that a number of providers, not just the Ministry of Health and Wellness, are responsible for providing health care and contribute to keeping the nation healthy. Other non-Ministry of Health and Wellness providers include private for profit, private not for profit and other government departments such as the Botswana Defence Force, Botswana Prison Service and Botswana Police Service. Traditional health providers are currently not regulated, nonetheless they were consulted during the revision of the National Health Policy of 2010.

Using the modified WHO Health System Framework, the National Health Policy stipulates the goal, objective and policy initiatives of each of the building blocks of a health system namely i) leadership and governance, ii) health service delivery, iii) lifestyle/behavior determinants of health, iv) health resources (human resources for health, medicines, vaccines and medical equipment, health infrastructure and health financing) and iv) health management information system. The policy also outlines the implementation framework, highlighting the responsibility of government departments, including the role of the parliament and the Office of the President. The policy also stipulates the need for monitoring and evaluating the implementation of the policy.

The Essential Health Services Package (EHSP) (2010)

As part of its mandate of providing health care to Batswana, the Ministry of Health and Wellness developed and defined a list of essentials also called minimum services. The document defined the minimum package of service that can be provided at different levels. The levels were defined as community/home, health post, primary health centre, primary hospital, district hospital and referral hospital. The EHSP also sets the norms and standards of providing service such as the minimum number of providers and facilities per population. The choice of service was mainly based on i) technically effective and can be delivered successfully; ii) services that target high burden diseases looking at effect at individual, social impact and economic effects; iii) sustainability of services and iv) equity. This means that rigorous review of research materials, previous service delivery reports and intensive consultations preceded the development of the EHSP.

Although the EHSP was comprehensive in including promotive, preventive, curative and rehabilitative service, it still needs to be used with other guiding documents. The EHSP document was very explicit that it only provides the 'what' of services and not 'how' the services would be provided. The District Health Management Teams (DHMTs) had the responsibility and autonomy to determining how they would provide the services. Alternative health systems are neither explicitly nor implicitly catered for in this package.

Other Guidelines

The Ministry of Health and Wellness also provides department or medical condition specific guidelines or strategies which help the health workers to provide services at standards that are acceptable, evidence based and up to date with best practices. Such examples include guidelines for management of HIV/AIDS, Cervical Cancer and hypertension. These guidelines continue to be reviewed as new evidence becomes

available. The guideline are mainly focused on mainstream medical practice not alternative health practices.

Study Findings

As stated above, apart from desk review, we consulted health policy makers and government officials on policies governing health provision in Botswana. Respondents who included government ministers, hospital superintendents, directors in different departments of the Ministry of Health and Wellness were agreed that the government does not have a specific policy on alternative health systems. In fact, MAPM003 said, strictly speaking the government had no policy, "policy is a big word, but we have a code of practice, guiding practices that are currently in place." He said this code is called a "collaborative partnership between us (medical practitioners) and the alternative medicine practitioners." The practice calls for patients to be given information to make informed choices. The policy calls for respecting an individual's religious beliefs in the provision of healthcare services.

Respondents said there is, however, an ongoing demand by some social players that the government should acknowledge alternative health systems, in particular traditional medicine. In the past, especially during the peak period of the HIV and AIDS scourge and during the period of diarrhoea outbreaks, efforts were made to educate and even collaborate with traditional healers to fight the problems (GAPM). K. E. Jensen and L. Katirayi (2011:158-179) give a detailed analysis of the collaboration of traditional healers to HIV response. They concluded that Botswana traditional healers willingly collaborated with medical doctors although the same was not true of the attitude of medical doctors towards traditional doctors.

Respondents also referred to the Revised National Health Policy (2011) saying it did not directly mention traditional and faith healers but uses the term 'private practitioners'. This means that they are not necessarily excluded because the policy also states that all efforts by all stakeholders will be incorporated in implementing the policy (TSPM). One respondent stated,

> "Now what is happening right now is to encourage all efforts for the well-being of the patients, because at the end of the day, the patient here is a client to all of them and the main point is to restore and maintain the health of the patient … the government is not stopping anybody from seeking treatment where he/she wants but it's not in black and white to consult traditional doctors, for instance" (TSPM).

Implications for Holistic Health Care

Writing on indigenous theories of contagious diseases, E. Green (1999:217-218) made a strong observation that, "Public health programs in developing countries…… would be more effective if those who design and implement programs possessed an empirically based understanding of existing ethnomedical beliefs and practices…" This is, however, not the case when one analyses Botswana health policies. Although a number of people in Botswana seek healing and health care services from faith and traditional healers (Togarasei, et al 2016), these healers are not recognized officially as health providers as seen in the policies and guidelines reviewed above. The Botswana health policies and

guidelines discussed above definitely have implications for the provision of holistic health in the country. Faith and traditional healers are not regulated, their practice is not standardized, and there is no recognized training. Guided by the above policies, respondents noted that the policies have implications for collaborations of the different health services providers in the country: biomedical practitioners, traditional and faith healers. They noted that although government has always worked closely with faith healers allowing them to pray for patients in hospitals and providing counselling services, this was not the case with traditional doctors. Traditional healers are not allowed to come and administer their medication in hospitals. They said there were now new efforts for collaboration with traditional healers but no clear policies have been developed. MAPM001 said the attention on traditional healers was out of the realization that many Batswana make use of the services of the traditional healers while questions remain on their medication: safety of the medication, the doses, property rights, etc. Like other respondents, GAPM001 noted that collaboration with traditional healers intensified during the height of the HIV pandemic. K. E. Jensen and L. Katirayi (2011) give an elaborate outline of the traditional healers during the height of the HIV pandemic. Policy makers acknowledged that this collaboration remains predominantly one way, with medical practitioners educating traditional healers on hygiene and the need for referring patients to hospitals and clinics. Policy makers said there was a strong government effort to engage alternative health providers, especially traditional healers as shown in government celebration of World Traditional Medicine Day annually. At the dissemination workshop for the results of our larger study mentioned above, the Minister of Health and Wellness also highlighted the Ministry's observation of World Traditional Medicine Day as an indication of government's willingness to closely work with traditional healer. Health policy makers also said they have different forums where the different health providers meet to share ideas. However, because of the lack of clear policies on alternative health practices, there was no defined collaboration among the different health providers. Medical doctors, for example, cannot openly refer patients to traditional doctors even if they feel that patients may find help there. Respondents said medical practitioners are not supposed to refer patients to traditional healers. For example, according to MOPM001, "In the hospitals we do not refer people to *dingaka* (traditional doctors), rather they are the ones who refer people to us." The reasons for not referring to traditional doctors were captured by MOPM001 who said, "here in the hospital when we treat we are able to diagnose and tell what a person is sick of. If its pneumonia, we can be able to tell and we will focus on treating that condition. If its diarrhoea I will deal with diarrhoea, but when they (traditional doctors) treat they'd not have diagnosis."

Respondents noted the importance of policies that encourage collaboration of all health systems for holistic health. They noted that use of alternative health systems promotes and takes advantage of indigenous knowledge reducing the medical imports bill drastically. One respondent pointed out that,

> It can be good economically, it can really boost economy because we are buying medicine from the West at great cost. Botswana is spending 3-4 billion Pula (US$300 million) each year on medication only, so we are spending a lot on that whereas we could save a lot on that or even export if we made use of our traditional medicine. Because indigenous knowledge has been looked down upon then it's the white people who came and told us some of our indigenous plants are good but we have always known that (GBPM).

They also noted that people have always had faith in faith and traditional healers. Promulgating policies that promote these alternative health practitioners would therefore promote holistic health. They noted that collaboration with organizations which engage people's faith helps in a quick promotion of health programs as people's response to modern medicine is influenced in many ways by their traditional, cultural and religious beliefs. One of the policy makers stated that,

> The ministry is trying to encourage collaboration, for example, via the health education meetings through DMSAC (District Multi-Sectoral AIDS Committee). Pastors' Fraternity and the fire people are engaged in the campaigns against diarrhoea, where they are given ORS to distribute to the patients who visit them. Most of the time, it is more effective when ORS is coming from the traditional or faith healers than when it is given by the nurse because of the faith people have in these people (TSPM).

Conclusion

There is limited documented official collaboration between the biomedical health care providers and faith/traditional health providers in Botswana. This is despite the fact that, according to the World Health Organization, there is a strong relationship between cultures, religion and alternative medicine – traditional, faith healing. As a result, there is so much secrecy on the interventions/treatments that are available in some countries. There is also limited data on evaluation of the effectiveness, safety and cost of the services and interventions which, when combined with absence of standardized training, poses a challenge in regulation of services and providers. All these have implications for holistic health services provision in Botswana.

The World Health Organization views the absence of regulation or other form of guidelines for the practice of alternative health care providers as a major gap in health care provision. It is estimated that alternate health providers care for a significant population in different countries. For instance: traditional medicine accounts for about 40% of all health care in China; 71% in Chile; 40% in Columbia and 65% of the rural population in India (WHO, 2003). In Ghana, Mali, Nigeria and Zambia, traditional medicine is the first line treatment option for more than 60% of children with high fever (WHO, 2003).

Given the population that is served by traditional medicine, it is imperative for governments, as the protectors of the citizens, to put a structure that would enable the regulation of alternate health providers which in turn will allow evaluation of safety and effectiveness of traditional health services and if possible foster collaboration and inter-referrals between alternative and biomedical health care. The problem of lack of policies means that the government does not know what is going on in the area of traditional medical practice.

In 2000, WHO noted that some countries had made some advances in recognizing alternative health care; for instance, it was estimated that 70 counties had regulation or registration procedures for herbal procedures while 25 counties reported to have a national policy for traditional medicine. Traditional Asian procedures such as Acupuncture have been demonstrated to be effective for certain conditions such as headache and chronic back pain and have been regulated in China and the US. Its safety has also been assessed and in some areas, there is collaboration and referrals between biomedical and

Acupuncture practitioners. This strengthens the argument that there is potential benefit to regulation and building of collaboration between alternative health care and biomedical care.

Having recognized the role of traditional medicine in countries where it is accepted and deemed valuable, the World Health Organization developed a strategy to assist member states. The strategy identifies the role of WHO (2003) as "…to broaden the recognition of traditional medicine, to support its integration into the nation's health system, to provide technical guidance and inform the safe and ethical use…" According to WHO, this would be achieved through developing policies, implementing programs and promoting safety, efficiency and quality by providing regulatory and quality assurance standards.

We therefore conclude this article by recommending that the Ministry of Health and Wellness consults with stakeholders and develop a policy framework for alternative health care. This will help in guiding the provision of alternative health, evaluation of safety, effectiveness of intervention and development of products and interventions. Botswana may learn from other countries like Nigeria that followed the WHO recommendations and developed Traditional Medicine Policy of 2007. The policy aims to develop and facilitate the use of Traditional Medicine in Nigeria in the official health care system, harness the potential and economic benefits of traditional medicine practice to accomplish the provisions of the National Economic Empowerment and Development Strategy (NEEDS) and establish a country-specific institutional framework for traditional medicine (Traditional Medicine Policy for Nigeria, 2007).

In cases where alternative health care was recognized, it grows and develops with regulation, registration and training of health care providers and significantly contributes to the population's health needs. For instance, in Australia, visits to complementary health professionals such as acupuncturists, chiropractors and naturopaths have been growing rapidly with an increase of over 30% between 1995 and 2005 while increasing recognition of alternative health care is recognized in China, Lao People's Republic and Saudi Arabia (WHO, 2013). Batswana have continued to use traditional healing services and the practice needs to be officially recognised and mainstreamed within the national health system.

Amon Marwiro is a public health practitioner who actively promotes health and wellness and support efforts in improving access and uptake of modern health care services. He has more than 19 years of clinical and public health experience in Botswana and Zimbabwe. His passions include strengthening health systems, improving the quality and efficiency of public health interventions and continuous community engagement in scaling up interventions that have a demonstrable public health impact. Dr Marwiro has intensive experience in community engagement during design, planning, implementation and monitoring of health interventions and programs. He is currently a Country Representative of an international non-governmental organization that supports the Botswana Ministry of Health and Wellness in improving health care and fostering community to facilitate interface with special attention to HIV/AIDS, other communicable and non-communicable diseases. He is a member of various Botswana Ministry of Health and Wellness technical working groups (TWGs). He is a holder of MBChB (Zim, 2003), Dip. HIV Management (SA, 2008), MPH (Zim, 2010) and MBA (UK, 2017).

Lovemore Togarasei (PhD) is Professor of Religious Studies at the Zimbabwe Open University where he teaches courses in biblical studies. He has also taught at the universities of Zimbabwe and Botswana. He was the Principal Investigator in the project in which the articles in this volume are derived. He has published widely and undertaken consultancy work in the areas of religion and health, gender, politics, prosperity gospel, leadership and popular culture. His latest edited book is *Lobola in Southern Africa* (Palgrave Macmillan, 2020). E-mail: ltogarasei@gmail.com

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