Has Donor Funding Been Able to Change the HIV/AIDS Policy Agenda in Botswana?

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Abstract

Despite optimism about the end of AIDS, the HIV response requires sustained financing globally into the future. Given flat-lining international aid, countries' willingness and ability to shoulder this responsibility will be central to access to HIV care. Donor funding for HIV programmes has increased rapidly over the past years, raising questions about whether other health services in recipient-country health systems are being crowded out or strengthened. The recognition of the AIDS pandemic as an epochal crisis has led to a proliferation of international and donor organization's now directly involved in governance, tracking and management. This paper examines funding of HIV/AIDS in Botswana and the relationship between foreign donors and Botswana government. It gives an illustration of how public- private partnerships approaches can be useful in the control of HIV/AIDS. It concludes by stating that since Botswana is going through an epidemiological transition and experiencing HIV/AIDS fatigue, new innovative health financing methods needs to be introduced.

Introduction

Donor funding for HIV/AIDS has reached levels unprecedented in the history of global health. Annual funding for AIDS in low-income and middle-income countries increased 30-fold from 1996 to 2006, from US$300 million to US$8.9 billion. While funding remains far short of the estimated need, international donor commitments for HIV/AIDS are significant, and likely to be so, well into the future (Bernstein *et al.* (2007). The resources for HIV/AIDS are a topic of considerable interest and debate internationally. However, little is understood about how these resources are actually being spent, and whether they are being made available as efficiently and effectively as possible for the fight against HIV/AIDS.

Despite optimism about the end of HIV/AIDS, and remarkable progress towards this ambition, a sustained HIV/AIDS response will be required for years to come. HIV/AIDS remains the fifth global cause of morbidity and mortality, and ranks second in sub-Saharan Africa (Murray *et al*. 2012). Unprecedented resources have been mobilised in response to the epidemic, reaching US$19.1 billion in 2013 in low-income and middle-income countries. Yet, this still falls short of UNAIDS previous resource needs estimates of US$ 24 billion by 2015 and its US$36 billion estimate for 2020 in the ambitious 'fast track' scenario meant to reduce the number of new infections and AIDS-related deaths by 90% by 2030 (UNAIDS 2014a). With the success of antiretroviral therapy (ART), HIV infection is no longer a death sentence, and national governments face the challenge of how to sustain their growing obligations and duty to maintain people on life-long treatment (Lule and Haacker 2012), alongside laudable commitments to continue scaling up treatment access for all those who are HIV-infected (UNAIDS 2014a). There is also the need to continue investing in HIV prevention to reduce the rate of new infections.

The International Monetary Fund (IMF) sets the 'sound' threshold for the debt burden of countries at 40% of Gross Domestic Product (GDP). Therefore, this hidden HIV-obligation is potentially of real economic concern for both governments and donors. Some now argue that HIV is a fiscal as well as a public health crisis, particularly in sub-Saharan Africa (Collier *et al*. 2015 and Vassall *et al*. 2013). To

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date, much of the HIV/AIDS response globally is depended on international financing. Only 10% of HIV/AIDS expenditures in 2013 were financed from domestic sources in low-income and lower-middle-income countries respectively (UNAIDS 2014a). However, with the flat-lining of external HIV/AIDS funding commitments, optimistic economic growth forecasts and the prospects of increased revenues from natural resources (Vassall *et al*. 2013), several global and regional declarations have called for African governments to fund more of their own responses (Buse and Martin 2012; Galarraga *et al*. 2013; Resch *et al*. 2015). In addition, there is a growing promotion of 'innovative financing' mechanisms such as earmarked taxes or diaspora bonds (Atun *et al*. 2012 and Katz *et al*. 2014) to create new sources of HIV/AIDS financing. A withdrawal or re-allocation of donor financing, without a compensating domestic financing response, may affect the continuity of care for those on treatment, and/or have high opportunity costs by removing financing from other critical areas of domestic spending both within or beyond the health sector.

Paradoxically, some of these other areas of spending may also be fundamental to the effectiveness of the HIV/AIDS response, such as education or the strengthening of health systems (McIntyre and Meheus, 2014; Seeley *et al*. 2012). It is, therefore, important to understand the factors that influence countries' potential ability to sustainably fund their national HIV response, without negatively impacting on spending in other critical areas or undermining macroeconomic conditions. Improving global health has received increased attention from international donors, with disbursements of development assistance for health increasing to $28.7 billion in 2009 from just over $10 billion in 2000 (UNAIDS 2014a). The added attention given to HIV/AIDS has been particularly striking. Donor funding for HIV/AIDS programmes doubled as a proportion of all development assistance for health from 2000 to 2007, and HIV aid increased nearly tenfold from 1992 to 2005. These trends have been even more pronounced in sub-Saharan Africa, where approximately half of all development assistance for health was allocated to HIV/AIDS.

The increased attention given to HIV/AIDS by international donors began decades ago, in the form of both increased support from existing donors and the establishment of new disease-specific programmes. The largest donor to the global AIDS response over the past decade has been the President's Emergency Plan for AIDS Relief (PEPFAR 2009), a United States (US) government programme established in 2003. The Kaiser Family Foundation estimated that as of 2010, the US government's annual contribution to PEPFAR was approximately $3.7 billion more than half of all donor-government disbursements to HIV programmes globally. Since the programme began, PEPFAR allocations to some recipient countries neared or exceeded those countries' entire national health budgets.

The exceptionally high priority given to HIV/AIDS by international donors has been the subject of controversy. In some recipient countries, support for HIV/AIDS programmes ranks low on public opinion surveys relative to other development priorities, even among people infected with HIV/AIDS (PEPFAR 2009). Concern has been raised that external donor support for HIV/AIDS programmes may be displacing or 'crowding out' these donors' support for other health programmes (PEPFAR 2009). The remarkable successes that donors supported HIV/AIDS programmes have achieved are widely recognised. By 2010 an estimated 6.6 million people were receiving antiretroviral (ARVs) medication, and millions more were obtaining HIV/AIDS care and prevention services (UNAIDS 2014a). What is debatable, however, is the overall impact that the rapid influx of new HIV resources has had on the health systems of recipient countries, especially on the delivery of non-HIV/AIDS health services.

In recognition of the need to address the problem of poorly coordinated response to HIV/AIDS, officials from African nations, multi-lateral and bilateral agencies, non-governmental organizations and the private sector reached a consensus around three principles appropriate to stake holders in national level response (Akbar 2005). These have become known as the 'Three Ones' as specified in the Paris Declaration and the Accra Agenda for Action. The Paris Declaration (2005) is a practical, action-oriented roadmap to

improve the quality of aid and its impact on development. It gives a series of specific implementation measures and establishes a monitoring system to assess progress and ensure that donors and recipients hold each other accountable for their commitments. The Paris Declaration as outlined in the Organisation for Economic Co-operation and Development OECD) covers the following fundamental principles for making aid more effective:

1. One HIV/AIDS action framework
2. One national HIV/AIDS Coordinating Authority
3. One country monitoring evaluation

In summary, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action seek to reform the way development aid is delivered and managed in order to strengthen its impact and effectiveness. However, it does not hold donors and countries accountable for development results in health or other areas (Akbar 2005).[3]

In the case of Botswana, since 2001, funding for HIV/AIDS from government and international donors has significantly increased. The country's remarkable improvement in its fight against HIV/AIDS has also been achieved through the active involvement, participation and generous support of foreign donors. Drug companies and non-governmental organisations (NGOs) are donating funds to the country's comprehensive prevention and treatment efforts. Botswana has received grants for its universal ARV drug programme totalling more than US$160 million from Bill and Melinda Gates Foundation and drug maker Merck over the years to help Botswana strengthen its health infrastructure (Sharma and Seleke 2009).

In addition, the Harvard AIDS institute has built a $4.5 million HIV/AIDS research laboratory in Gaborone and is also training health workers to address the epidemic. Botswana has also received $20 million in 2004 and $40 million in 2005 (Sharma and Seleke 2009). Botswana is also a beneficiary of the US President's Emergency Plan for AIDS Relief (PEPFAR) which also distributes ARV medication through the country's public health system, and has received $343 million (Sharma and Seleke 2009). PEPFAR provides funding to well over 100 countries. The organisation's portfolio is overseen by the Office of the US Global AIDS Coordinator (OGAC) based in Washington DC. The country has also received $70 million for the year 2007, from the US Embassy in Gaborone. Botswana has also been receiving substantial funding from the Global Fund. The Global Fund provides grants for HIV/AIDS, tuberculosis and malaria. To receive money from the Global Fund, a country must establish a Country Coordinating Mechanism (CCM) made up of stakeholders from government and civil society (Rualiri *et al*. 2004). However, the last time the country received from Global Funding was in 2008 because $65 million was withdrawn from the fund due to alleged mismanagement of the fund (Sharma and Seleke 2009).[4]

Botswana has also received financial aid through The Multi-Country AIDS Programme for Africa (MAP). MAP is different from other types of World Bank assistance. Established in December 2000 after specific funding authorisation by the World Bank's Board of Directors, MAP programmes are designed as a way of strengthening a country's capacity to develop a national response to the AIDS epidemic. All countries that wish to receive MAP funding are required to develop a national AIDS plan; they must also establish a National Aids Council (NAC) to oversee and coordinate the implementation of this plan (Bernstein *et al*. 2007).

3 Also see www.adb.org/aid-effectivenes, accessed 3 August 2017

4 Also see www.theglobalfund.org/media, accessed 3 August 2017

An Overview of HIV/AIDS in Botswana

In the 50 years since independence, the government of Botswana has made it a priority to ensure equitable access to healthcare for its citizens. Total health expenditure (THE) in Botswana was US$397 per capita in 2013, with government health expenditure (GHE) per capita amounting to US$227.[5] Although GHE per capita has remained relatively constant since 2005, financing for health has been boosted by the growth of private health insurance. Private prepay expenditure per capita in Botswana grew from US$3 in 2003 to US$136 in 2013.[6] Despite the increase in private health insurance expenditure on health, Botswana's health system remains dominated by the public sector. Public care is based on a primary healthcare model, with health posts and clinics making up 95% of government health facilities. Many clinics are supported by donor funding as part of the response to HIV; however, international donors are beginning to reduce this funding. PEPFAR funding fell from more than US $90 million in 2010 to US$40 million in 2015.[7] The strengthening of the private sector has offset much of this reduction in funding, but Botswana will need to continue identifying new resources to ensure the sustainability of its HIV response and the health sector as a whole.

However, HIV/AIDS remains the most significant social and public health problem in Botswana. The country is experiencing one of the most severe HIV/AIDS epidemics in the world, affecting both urban and rural areas with equal ferocity (UNAIDS 2015). Despite the strong health system foundation, responding to this massive epidemic has severely stressed the existing human resources and health system infrastructure. There is a health personnel gap compounded by increased demand to focus on cost effectiveness of service delivery and financial management issues (UNAIDS 2015). Since the beginning of the epidemic the government of Botswana has shown a high level of commitment in mitigating the impact of HIV/AIDS.

The government has committed domestic resources to support AIDS prevention, care and treatment which amount to 2-3% of GDP. The government also contributes between 80-90% of the required resources for HIV/AIDS treatment. For the past several years the government made commendable achievements in the fight against HIV/AIDS. Some of the strong success stories include the National Antiretroviral programme, Prevention of Mother to Child Transmission (PMTCT) counselling and treatment services reach over 95% of pregnant women, strong National HIV/AIDS Counselling and Testing (HCT) and routine testing programmes nationwide (Republic of Botswana 2014). These achievements were made possible with financial and technical contribution from the US government and other development partners.

At the turn of the twenty first century Botswana, with a tiny population of less than two million people at the time, was identified as one of the countries with the highest rate of HIV infection in the world, (UNAIDS 2015). Today after almost 32 years of the epidemic, Botswana is still considered as the epicentre of the virus within the Southern African region (UNAIDS 2015). The Botswana Impact Survey (BAIS IV 2013) data yielded a national prevalence rate of 19.2% females and 14.1% males. UNAIDS (2015) reported similar figures and also showed that women aged 15-49 years living with HIV/AIDS stood at a whopping 190,000 with Men at 172,000.

Botswana's Response to HIV/AIDS

The unprecedented devastating impact of the HIV/AIDS epidemic in Botswana placed it right at the centre of the worldwide fight against the disease. In the late 1990s, under the political leadership of Sir Ketumile Masire, Botswana became a fundamental test case for the effectiveness of the HIV/AIDS global response (Muxugata de Carholho 2006). The government's efforts to overcome the epidemic were very

5 www.healthpolicyproject.com/pubs/7887/Botswana, accessed 18 August 2017
6 www.healthpolicyproject.com/pubs/7887/Botswana, accessed 18 August 2017
7 www.healthpolicyproject.com/pubs/7887/Botswana, accessed 18 August 2017

favorably viewed by the international community of donors, multilateral agencies and NGOs. Botswana's stable political institutions, responsible government and well-run economy built a strong sense of trust among international partners. The generous international offers of human, technical, financial and material resources to fight HIV/AIDS are clear evidence of that fact. Notwithstanding their conflicting policy priorities, state donors, mostly the US, and multilateral and bilateral agencies found in Botswana a fertile ground for working with local HIV/AIDS actors and for fully developing their policy strategies to combat the epidemic (Muxugata de Carholho 2006).

Botswana therefore, confronted the problem with a high degree of commitment. The first case of AIDS in the country was officially reported in 1985. From the time of the first notification onwards the number of HIV infections soared rapidly, cutting across all social groups and economic classes (Muxugata de Carholho 2006). The first phase of the national response (1987-1993) coincided with the beginning of the worldwide expansion of the epidemic. This was followed by a series of 5-year strategic plans (Heald 2005, Republic of Botswana 2014 and NACA 2015). For instance, in 1988 the government of Botswana set up the National Aids Control Programme (NACP) and developed a Short Term Plan (STP). It was followed by a more comprehensive five year plan (1989-1993), named the First Medium Term Plan I (MTP I), (Sharma and Seleke 2009). These two plans were based on the action framework provided by the WHO's Global Programme on AIDS. During this initial stage, WHO collaborated closely with Botswana's Ministry of Health in implementing policies focusing mainly on HIV/AIDS surveillance and control (WHO 2013; Muxugata de Carholho 2006; NACA 2014 and UNAIDS 2014a UNAIDS 2014b).

HIV/AIDS awareness was promoted in attempts at changing sexual behaviour. The first national campaign in 1988 used radio messages with the campaign slogan Avoiding AIDS is as easy as 'ABC – Abstain, Be faithful, Condomise'. Hence, AIDS became known as the 'radio disease' (Heald 2002). These campaigns had a very limited impact nonetheless. There was minimal success in getting people to change their behaviour, this situation was not helped by the fact that in the mid-1990s the international agencies had largely withdrawn from Botswana, taking the view that given the wealth of the country, their resources could be utilised elsewhere (Allen and Heald 2004). Botswana was then left to fund almost all of its HIV/AIDS control programmes, making them an immediate drain on the national resources (Allen and Heald 2004). Again, until the early 90s Batswana were still in the stage of denial, it only really cascaded though from 1999 one year after Festus Mogae took office as President of Botswana.

In 2001, with the toll of HIV/AIDS rising President Mogae pledged to make HIV a national priority. He warned that 'Botswana is threatened with extinction'. Mogae had to act and thus declared HIV/AIDS a national emergency. And, therefore, developed a national strategic framework to turn the tide of the HIV/AIDS epidemic (Sharma and Seleke 2009). This was a bold statement at the time, when many leaders around the world remained in a state of denial about HIV.[8] In 2001, his government also introduced an ambitious treatment programme aptly named *Masa* ('New Dawn'), an initiate that gave hope to those living with the virus. The *Masa* programme manifests itself in public private partnership developed between the government of Botswana and African Comprehensive HIV/AIDS Programme (ACHAP), Merck and the Bill and Melinda Gates Foundation. The *Masa* programme provided free ARV medication and counselling. According to the UNAIDS report (2010) Botswana's national expenditure on health increased over the years recording 42% in 1995, 47% in 2000 and 75% for 2008 nationwide.

By 2012, total annual spending on HIV/AIDS had reached US$347 million in Botswana, of which 68% was covered by government, a remarkable sum for a sub-Saharan country, but a challenge for the government to sustain. The Bill and Melinda Gates Foundation contributed US$50 million and the Merck Foundation US$56.6 million to get *Masa* up and running; each contributed another US$30 million in 2010. The remainder came from international sources, including PEPFAR and The Global Fund to Fight

8 http://millionssaved.cgdev.org/case-studies/botswanas-mass-antiretroviral-therapy-program, accessed 10 October 2017

AIDS, Tuberculosis and Malaria.[9]

Merck drug companies as well as glamour Aid NGOs are donating funds to the country's comprehensive prevention and treatment efforts. Botswana has previously received numerous grants for its universal ARV drug programme totalling more than $100 million over five years from 2000 to 2005 provided by the Bill and Melinda Gates Foundation as well as Merck (Republic of Botswana 2013). Merck also committed $50 million over the years to help Botswana strengthen its health infrastructure.[10]

The Global Fund, which focuses on fighting Aids, TB and Malaria, has also made significant investment in HIV prevention in Botswana since 2004 to date (2018). From 2004 to 2006, the Global Fund disbursement was $9 million for HIV/AIDS (The Global Fund 2015) . In February 2016, Botswana received US$27 million provided through Global Fund. The funds were used for testing and counselling, PMTCT, advocacy initiatives, coordination and partnership initiative.

Although the Global Fund made significant contributions in the HIV/Aids funding in Botswana, in 2007 about $65 million was withdrawn from the Fund due to alleged mismanagement of the fund and failure to comply with conditions set by donors (Sharma and Seleke 2009). The overall goals of the grants are to achieve zero local malaria transmission or the elimination of malaria, to prevent new HIV infections, reduce morbidity and mortality as well as to enhance the psychosocial and economic impact associated with TB (The Global Fund Report 2016). It also aims to have all TB patients tested for HIV in order to provide treatment (The Global Fund Report 2016). Additionally, the funds target strengthening the procurement and supply management capacity at national and sub-national levels as well as reinforcing national health information systems (The Global Fund 2016).

The United States has been supporting Botswana's effort in the country's struggle against HIV/AIDS response mainly through PEPFAR. Efforts by government with strong support from the civil society, and development partners have seen the country make notable progress towards epidemic control (PEPFAR 2009). PEPFAR also collaborates with the government of Botswana to maximize the quality, coverage, and impact of the national response to HIV/AIDS. PEPFAR investments are aligned to national priorities and support interventions known to be most effective in preventing HIV transmission (PEPFAR 2009). Specific priorities include preventing the mother to child transmission, targeting treatment, care and support for key and vulnerable populations, scaling up voluntary medical make circumcision (VMMC), averting gender-based violence and strengthening HIV testing and counselling (PEPFAR 2009 and UNAIDS 2014a).

Botswana has also been receiving support through the USAID. In the fiscal year 2009 the country received $15.8 million for essential HIVAIDS programmes and services (UNGASS, 2010). USAID's HIV/AIDS programmes in Botswana are implemented as part of PEPFAR. In 2010, PEPFAR/Botswana and USAID/Botswana supported initiatives in several critical areas, including civil society capacity building, prevention of sexual transmission of HIV, care and support especially for orphans and vulnerable children (OVC) and gender (UNGASS 2010). There are also additional programmes at the national level planned to address the issues of multiple-concurrent partnerships, alcohol abuse and support for ARVs (UNGASS 2010). Table I below demonstrates PEPFAR over 2004 to 2015 period.

Table 1: PEPFAR Planned Funding in Botswana, 2004-2015 (millions in US$)

2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
$26	$52	$55	$76	$93	$92	$87	$84	$76	$61	$40	$39

Source: http://www.pepfar.gov/countries/botswana/index.htm. Accessed 15th November 2017

9 http://millionssaved.cgdev.org/case-studies/botswanas-mass-antiretroviral-therapy-program, accessed 10 October 2017

10 http://millionssaved.cgdev.org/case-studies/botswanas-mass-antiretroviral-therapy-program,www.researchgate.net/profile/Patricio_Marquez/publication/304748652_Botswana_Health_and_HIVAIDS_Public_Expenditure_Review/links/57795a4208ae1b18a7e62111/Botswana-Health-and-HIV-AIDS-Public-Expenditure-Review.pdf, accessed 10 October 2017

Donor Participation, Health Expenditure and Outcomes

Botswana's response to its HIV/AIDS crisis has been one of gradual expansion of comprehensive care for its HIV-infected citizens, such that Botswana is regarded as the beacon of hope for the rest of the continent suffering from HIV/AIDS (Republic of Botswana 2008). Overall, Botswana has made significant strides in addressing HIV/AIDS, particularly in the area of biomedical prevention, where both PMTCT and ART continue with strong implementation, exceeding the targets and commitments of the 2011 United Nations Political Declaration on HIV and AIDS General Assembly (Republic of Botswana 2014). Transmission of HIV from mother to child has reduced from as high 30% before the roll out of the program to as low as 2.1% based on program data in 2013. Although remarkable successes have been achieved through HIV response and interventions, Botswana faces greater challenge of sustaining its success without significant donor support.

Botswana developed a relatively high resource treatment model termed the 'Rolls Royce Model' at the time of inception of its treatment programme in 2001 (ACHAP 2001). Botswana's health care system and service delivery remains arguably one of the best in Africa and the world. A closer scrutiny of Botswana's National Health Accounts bears testimony to this with a large proportion that is over 80% of Total Health Expenditure (THE) is provided by government. Although faced with health financing challenges, to this day Botswana's 'Rolls Royce' Treatment model continues to be a model of success having started from the humble beginnings with an enrolment of 21,431 people in 2004 to a 95% enrolment rate of people in need of ARVs in 2011 (UNAIDS 2014a and b?). As at September 2011, a total of 172,920 clients were on the ARV treatment. This number translates to 95% of adults and children receiving treatment out of the eligible 182,127 people eligible nationwide. Of these clients 82% were provided for under the public health services, while the rest were either outsourced or covered by the private sector (BAIS IV). Key features included ARV treatment at specialised clinics provided by health workers dedicated to providing the ARV drugs, and patient management guided by intensive lab testing CD 4 count and viral load tests, and PMTCT.

The African Comprehensive HIV/AIDS Partnerships (ACHAP) played a major role in initiating Botswana's antiretroviral (ARV) programme in 2001. ACHAP is a prominent public-private partnership involving Merck and its foundation, the Bill and Melinda Gates Foundation, and the government of Botswana.[11] ACHAP started as a five-year partnership (from July 2000 to July 2005) between Merck and its foundation, the Bill and Melinda Gates Foundation, and the government of Botswana. ACHAP was created with a financial commitment ofUS$100 million, half each from Merck and Gates, to support prevention, care, and treatment for HIV/AIDS in Botswana, (Ramian *et al.* 2005; Sharma and Seleke 2009).

One of its major activities is to support the national ARV treatment programme –*Masa*. ACHAP also provided financial support for *Kitso* ('Knowledge') a training initiative for health care workers in the ARV programme. The ACHAP model has five key elements. Firstly, both Merck and the Gates Foundation decided to focus substantial resources in one country and on HIV/AIDS. The objective was to make a meaningful difference in a single country. Secondly, ACHAP aimed to provide comprehensive support including HIV/AIDS prevention, treatment, and care in recognition of the many links among these areas. Thirdly, ACHAP was designed to include the government of Botswana as both partner and grantee. The government became involved in approving proposals and then received a large part of the funds. Fourthly, ACHAP sponsors are extensively involved in designing and implementing the projects that they support. Both Gates and Merck believed that the private sector had much to contribute in ensuring that the funds were used effectively. This reflected some of the new trends in corporate philanthropy that emphasize the active engagement of private-sector partners. ACHAP is committed to building institutional capacity within

11 www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.545, accessed 20 February 2018

the government of Botswana. Lastly, ACHAP has sought to respond to government requests to recruit and pay trained foreign professionals and then place them in positions within government institutions (Ramian *et al*. 2005).

In the main ACHAP's experience with the ARV programme presents an important contribution to Botswana's fight against HIV/AIDS. To this day the ACHAP model continues to be a model of success having started from the humble beginnings with an enrolment of 21,431 people in 2004 to a 95% enrolment rate of people in need of ARVs in 2011. By September 2011 some 172,920 clients were receiving ARV treatment. This number translates to 95% of adults and children receiving treatment out of the eligible 182,127 people eligible nationwide (*Mmegi* 2 December 2011). Of these clients 82% were provided for under the public health services, while the rest were either outsourced or covered by the private sector (*Mmegi* 2 December 2011).

Botswana's PMTCT programme remains strong and well implemented. The estimated under 18 month HIV prevalence of BAIS IV was 2.2%. PMTCT programme reported 2.1% transmission rates and the 2013 Botswana National Spectrum model estimates were 2.49%, demonstrating agreement of the PMTCT rates across three data sources, (Republic of Botswana 2014). The country has one of the commendable PMTCT programmes in Africa, where 96% of babies born under the programme are HIV negative (PEPFAR 2015). This uptake presents a remarkable improvement and gave hope to Botswana's target of total elimination by 2016. The uptake of the PMTCT programme increased from 27% in 2002 to 94% in 2011 with a transmission rate from an estimated 40% to 2% (*Mmegi* 2 December 2011). This surpasses the Global Universal access target by 5% (*Mmegi* 2 December 2011). The national prevalence rate is at 17.6%, with HIV/AIDS deaths reduced by 60% from an estimated 14,000 to 6,000 by the end of 2010 since the introduction of ARVs in 2003 (*Mmegi* 2 December 2011).

Botswana's PMTCT is now challenged with how best to improve service delivery through integration both within the Antiretroviral Treatment Programme and within Sexual Reproductive Health. Despite the success of PMTCT and achievements by ACHAP, it has to be acknowledged that the country has been severely constrained by resource capacity in terms of financing the treatment model as well as other prevention methods. The expansion of the ARV treatment programme over the years has inevitably put pressure on other development priorities. For example, commenting on Botswana's health budget allocation for 2007/2008 Joyce Tamocha, President of Botswana Nurses Association (BNA), stated that in addressing health issues it was important to look at it holistically. She also expressed concern that the budget seems to focus on HIV/AIDS but silent on 'other sicknesses such as diabetes and cardiac problems, as more people are using pace makers' (*Mmegi* 6 February 2007).

Botswana health ratios expenditures increased over the years, focusing predominantly on HIV/AIDS. Currently, Botswana is spending tremendous amounts of money to keep people on treatment. For example, the total AIDS budget allocation of P981 million (US$ 98.1 million) for 2011/2012, ARV alone accounted for P188 million (Government of Botswana, Budget speech). In the 2017 financial year budget, the second largest share amounting to P6.5 9 billion or 16.6 percent of the total Ministerial Recurrent Budget was proposed for allocation to the Ministry of Health and Wellness. This will mainly cater for provision of; drugs, dressings vaccines, anti -retroviral therapy, replacement of obsolete medical equipment, and the implementation of the Treat All Strategy for HIV/AIDS (Government of Botswana, Budget Speech 2017).

Policy Analysis

An interesting thing about the Botswana case is that at the time when the epidemic was spreading most quickly in the country (in the early 1990s), the government of Botswana slowed down the response (Muxugata de Carholho 2006). Sir Ketumile Masire's government formulated the Presidential Directive of a National AIDS Policy (NAP). This policy document articulated for the first time government's concerns

about the impact of the epidemic on the country's development. It acknowledged the multi-dimensional impact of HIV/AIDS and mobilised a variety of sectors to collaborate on the national response. NAP represented a significant change in the policy debates on HIV/AIDS in Botswana. Its portrayal of HIV/AIDS as a development issue had a significant impact on how the epidemic would be presented in public debates in subsequent years. NAP defined new policy standards that were further consolidated with the adoption of the second Medium Term Plan for the period 1997-2002 (MTP II). This revised strategic plan substantially changed the focus of HIV/AIDS interventions from a health-based approach to a comprehensive multi-sectoral response (Muxugata de Carholho 2006).

In the politics of AIDS, the case of Botswana is puzzling. It challenges the common belief that economic underdevelopment and HIV spreading are directly related. The government of Botswana closely followed international medical guidelines for action. In Botswana, on the other hand, financial resources have never been the most critical constraint on the formulation and implementation of HIV/AIDS national plans. Although the government still relies significantly on multilateral and bilateral donors to fund HIV/AIDS activities (Muxugata de Carholho 2006).

The transfer of power from Ketumile Masire to Festus Mogae in April 1999 represented a watershed event in Botswana's HIV/AIDS national response. Mogae's proactive role at the NAC gave new impetus to Botswana's HIV/AIDS response. In the first year of the new administration, the government of Botswana, under the directive of the President's office, put in place the National AIDS Coordinating Agency (NACA). This new organ replaced the outdated National Aids Control Programme (NACP) of the Ministry of Health. In terms of the political management of HIV/AIDS, the most important institutional change brought by NACA was the shift in the locus of leadership from the Ministry of Health to the Office of the President. Chaired by President Mogae himself, NACA became responsible for mobilising material and human resources and coordinating the national response at all levels of decision-making (NACA 2015). In collaboration with many national and international partners, NACA set up a national committee to revise the MTP II and formulate a new strategic framework to facilitate its further implementation. This new framework aimed to provide clear guidance for ministries, NGOs and the private sector as well as to enable them to work in a collaborative manner under the centralised authority of NACA (NACA 2002).

Masire had epitomised the kind of transformational political leadership that has sustained Botswana's political stability since independence (Mhlanga 2015). Masire's political philosophy, his leadership style and the underlying internal and external factors that faced the country present valuable lessons to the rest of Africa and the world with respect to the success and failures of the country in diminishing the HIV/AIDS scourge. Masire, however, must have been fatigued or stressed.

Therefore, it must be noted that Mogae inherited a public health system that was fatigued. Almost all the intervention treatment and prevention programmes that were introduced during Masire's time had failed to perform wonders. Mogae confronted the situation with seriousness and vigour. Previously, Masire had made attempts to confront the situation without much success. During his tenure, there was an explosive rate of HIV/AIDS infections, leaving many people dead and families devastated. When Mogae came into office, most people had lost hope, almost every weekend there were burial of HIV/AIDS victims (Dow and Essex 2000).

Conclusion

The unprecedented devastating impact of the HIV/AIDS epidemic in Botswana seems to have placed the country at the centre of the worldwide fight against the disease. In the late 1990s, Botswana became a fundamental test case for the effectiveness of the HIV/AIDS global response. Government's efforts to overcome the epidemic were favourably viewed by the international community of donors, multilateral agencies and NGOs. Botswana's stable political environment, responsive government and a relatively

well-run economy built a strong sense of trust among international partners. The generous international offers of human, technical, financial and material resources to fight HIV/AIDS are clear evidence of that fact as evidenced from the discussions in the paper.

The increased attention given to HIV/AIDS treatment and prevention by international donors, including PEPFAR has certainly been a beneficial development. Advocates for many developing world health and population issues have expressed concern that the high level of donor attention to HIV/AIDS is displacing funding for their own concerns. Although Botswana has received many accolades of being an African economic success story, HIV/AIDS has had devastating effects on its health budget over the years. Despite the remarkable strides that Botswana has made there are still significant health gaps between different sectors of the population, with the inhabitants of rural areas being highly disadvantaged.

In response to the pandemic, Botswana has had to get into partnership with donors such as ACHAP and Bill and Melinda Gates Foundation as well as other players such as PEPFAR, Global Fund, and USAID. The success of the ARV and PMTCT in Botswana are a clear demonstration that whilst Botswana has recorded phenomenal economic growth starting in the 1980s, foreign donor assistance contributed significantly in the war against HIV/AIDS. However, as President Ian Khama (2008-2018) noted in his speech at the commemoration of the World HIV/AIDS Day in Moshupa 2011, Botswana is experiencing financial shocks as a result of having had to shift her policy agenda and focus more on trying to achieve zero levels of HIV and AIDS (BOPA December 2011). There is need for the continuation of international support for Botswana from the various players. There is also need for continued strong political commitment and participation of community and all the relevant stakeholders in the country.

References

Official documents

Republic of Botswana 2001. Botswana National Strategic Framework for HIV/AIDS, 2003-2009. Gaborone: Pyramid Publishing.

Republic of Botswana 2008: The Botswana AIDS Impact Survey III (BAIS III), Statistics Botswana, Government Printing, Gaborone, Botswana

Republic of Botswana: The Botswana AIDS Impact Survey III (BAIS III), Statistics Botswana, Government Printing, Gaborone, Botswana.

Republic of Botswana 2008. Botswana HIV/AIDS Third Medium Term Plan. Gaborone: Lentswe La Lesedi Publishers.

Rebublic of Botswana, NACA 2014, Government Printing, Gaborone, Botswana.

http://www.achap.org/treatment.php

https://www.pepfar.gov/countries/cop/2009/index.htm

http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2014.pdf

http://www.unaids.org/sites/default/files/country/documents/BWA_narrative_report_2015.pdf

http://ghdx.healthdata.org/record/botswana-ungass-country-report-2010

https://www.theglobalfund.org/en/portfolio/country/list/?loc=BWA&k=2d777324-7b1f-48ad-a1e0-72f6e4d2b646

https://afro.who.int/health-topics/hivaids

http://www.who.int/hiv/HIVCP_BWA.pdf

Secondary sources

Akbar, N 2005. 'Scoring the Millennium Goals: Economic Growth v/s Washington Consensus', Journal of International Affairs, vol. 58, pp.233-244.

Atun, R, Knaul, FM, Akachi, Y, Frenk, J 2012. 'Innovative Financing for Health: What is Truly Innovative?'

Harvard Global Equity Initiative, Boston, MA, USA, 380, pp.2044-2049.

Buse, K and Martin, G 2012. 'AIDS: Ushering in a New Era of Shared Responsibility for Global Health', Globalization and Health 8(1):26

Collier, P, Sterck, O and Manning, R 2015. 'The Moral and Fiscal Implications of Antiretroviral Therapies for HIV in Africa', CSAE Working Paper No. WPS/2015-05.

Colombo, A, D'Aoust, O and Sterck, O 2014. 'From Rebellion to Electoral Violence: Evidence from Burundi. ECARES Working Papers.

Dow U, Essex M 2011. Saturday are for Funerals, Harvard University Press, USA

Galarraga, O, Wirtz, VJ, Santa-Ana-Tellez, Y and Korenromp, EL 2013. 'Financing HIV Programming: How Much Should Low- and Middle-Income Countries and their Donors pay?' PLoS One 8(7), p.665-675.

Gustav, R 2011. 'Giving Up on AID', CATO Journal, vol. 31, No. 11 pp.75-78.

Ilavenil, R and Reich Michael R 2005. 'Public Private Partnerships and Anti-retroviral Drugs for HIV/AIDS Lessons from Botswana', Health, vol. 24 (2), pp.545-551.

Heald S 2005. ' Abstain or die: The development of HIV/AIDS Policy in Botswana, Cambridge University Press, UK

Held, D 2005. 'At the Global Cross Roads: The End of the Washington Consensus and the Rise of Global Social Democracy', Globalizations vol. 2, p.95-113.

Katz, I, Routh, S, Bitran, R, Hulme, A, and Avila, C 2014b. 'Where Will the Money Come From?: Alternative Mechanisms to HIV Donor Funding', BMC Public Health p.956.

Mhlanga B 2015. 'Africa's-transformational Postcolonial Leadership and Colonial-antinomies', African Journal of Rhetoric: Transitions and Transformative Rhetoric vol. 7, pp.93–128.

McIntyre, D and Meheus, F 2014. 'Fiscal Space for Domestic Funding of Health and Other Social Services', Health Econ Policy Law. 2017 Apr;12(2):159-177

Moyo, D 2010. 'Dead Aid: Why Aid is not Working and How There is a Better Way for Africa', New York: Farrar, Straus & Giroux. Pages 257-261

Murray, CJ, Vos, T, Lozano, R, Naghavi, M, Flaxman, AD and Michaud, C 2012. 'Disability-adjusted Life Years (DALYs) for 291 Diseases and Injuries in 21 Regions, 1990-2010: A Systematic Analysis for the Global Burden of Disease Study 2010'. Lancet. 2013, pp.2197-2223.

Ooomman N, Berstein M, Rosenzweg 2007. A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund and World Bank in Mozambique, Uganda, Zambia. Centre for Global Development, Washington DC, USA

Resch, S, Ryckman, T, Hecht, R 2015. 'Funding AIDS Programmes in the Era of Shared Responsibility: An Analysis of Domestic Spending in 12 Low-income and Middle-income Countries', Lancet Global Health, vol 3 pp.52-61.

Rose, P 2003. 'From the Washington Consensus to the Post Washington Consensus: The Influence of International Agenda on Education Policy and Practice, Malawi', Global Society, vol. 1, pp.67-86.

Renwick, N 2007. 'Global Society and Response to HIV/AIDS: Botswana Experience', Global Society, Journal, vol.21, 2, pp 133-153

Seeley, J, Watts, CH, Kippax, S, Russell, S, Heise, L, Whiteside, A 2012. 'Addressing the Structural Drivers of HIV: A Luxury or Necessity for Programmes? Journal of the International AIDS Society 15 Suppl 1(Supplement 1):1-4

Sharma KC and Seleke TL 2009. 'HIV/AIDS in Africa: Botswana's Response to the Pandemic', in Pinkowski, J, Disaster Management Handbook. New York: CRC Press, Taylor and Francis Group.

Skarbek D and Leeson P 2011. 'What Aid Can't Do: Reply to Ranis', CATO Journal, vol. 31, pp.83-86.

Quinis, Z 2005. Rethinking the Emerging Post Washington Consensus. ERC Working Paper in Economic 03/09

Vassall, A, Remme, M, Watts, C 2012. 'Social Policy Interventions to Enhance the HIV/AIDS Response in sub-Saharan Africa', in Lomborg, B (ed.), Rethink HIV: Smarter Ways to Invest in Ending HIV in Sub-Saharan Africa. Cambridge: Cambridge University Press.

Newspaper source

Mmegi 2 December 2011. 'Current Aids Budget Too Expensive, Khama'.