

Extract from Bridging Research and Policy on HIV/AIDS in Developing Countries – Country Study: Botswana

Background

Botswana provides a surprisingly unfortunate case in looking at research-policy linkages on HIV/AIDS. The country has long been viewed as an African economic success story and remains economically strong. Yet, it has failed dismally regarding HIV prevention: the country now has one of the highest prevalence rates of HIV/AIDS in the world. It is estimated that 39% of adults between the ages of 15 to 49 have HIV/AIDS. However, Botswana also provides an interesting case since it has the financial ability to provide massive treatment and care programmes – and has moved ahead with them.

The first official case of HIV in Botswana was identified in 1985. But it was not until 2000 that Botswana started to implement a strategy that reflected the magnitude of the problem. The National AIDS Coordinating Agency (NACA) was set up and given responsibility for mobilising and coordinating a multi-sectoral national response to HIV and AIDS. In 2000, the Cabinet declared AIDS a national emergency, allowing HIV/AIDS funding to be considered at any time and not to be tied to the annual budget. Considerable extra resources were put into HIV/AIDS prevention and care activities.

In an address to the UN General Assembly in 2001, the President of Botswana, Festus Mogae, said ‘we are threatened with extinction. People are dying in chillingly high numbers.’ Botswana became the first country in Southern Africa with a national programme offering the total package of comprehensive care through the public health system, including the provision of drugs for opportunistic infections and treatment with antiretrovirals.

The Botswana case raises two sets of questions for this project. First, why did it take so long for a meaningful policy response? Secondly, since Botswana is implementing treatment and care programmes ahead of all other countries in Africa, what does this tell us about bridging research and policy in the implementation phase of such programmes? These questions will be addressed through the lens of the RAPID framework. To complement the analysis, please refer to Table 4 on the milestones regarding each of the main arenas.

Table 4: Botswana HIV/AIDS milestones and the RAPID framework

Date	Context	Evidence	Links	External influences
1966 to present	Peaceful context since 1966; prosperous through diamonds.			
1985	Health services better than other sub-Saharan African countries.	Botswana's first AIDS case reported.	NGO also active in filling gaps in health services.	AIDS issues prominent in West; Botswana warned of impact of HIV/AIDS on national economy.
1987	Screening of blood made compulsory.			
1989	Introduction of narrow information, education and communication programmes.	Survey of donated blood reveals HIV prevalence.		
Early 1990s	Government adopted Botswana National Policy on AIDS (1993).	First annual national sentinel surveillance (1992).		
1996		Initial BIDPA reports on impact of HIV.	Botswana National Youth Council launches Sex and AIDS Project; YOHO set up – provides sex education.	Norway support for Men, Sex and AIDS Project.

⁵ For useful background information, see www.avert.org/aidsbotswana.htm.

1997	Response to HIV/AIDS broadened and deepened (MTP II).			Government and UNDP first sign HIV/AIDS Programme Support Document.
1999	African Comprehensive HIV/AIDS Partnerships (ACHAP) established.	'Severest epidemic in world' – estimates 36% adults positive.		BOTUSA (Botswana and the US) established to provide additional funds.
2000	National AIDS Co-ordinating Agency (NACA) set up, chaired by president. AIDS declared national emergency.	VCT centre established. Harvard AIDS Institute and government launch HIV study.	'This country has been bombarded with HIV messages, but there hasn't been a change in behaviour' (Avert).	African regional meeting on pilot projects for the prevention of mother-to-child transmission of HIV done in Botswana in March.
2001	Government signs UNGASS document.		Government, Merck, Gates Partnership – total package of treatment and care.	World Bank launches Multi-Country AIDS Programme (MAP).
2002		Survey: successful social marketing of condoms (AHCAP).		
2003	President Festus Mogae radically shifts AIDS policy. Routine HIV testing of everyone who enters hospital or clinic, unless patient objects.	Uganda and Botswana only countries in Africa to receive free nevirapine, which prevents MCT.		President Bush promises that the US will 'do everything it can' to help Botswana reduce the incidence of HIV/AIDS.
2004	Anti-retroviral drugs provided for free to all Botswanan who needs them (MASA).	Stigma severely hampered government efforts to provide AIDS drugs (UNAIDS).	The president, a Botswana chief and 30 tribal leaders undergo HIV testing to reduce stigma.	

Political context

Botswana is relatively wealthy and has a democratic polity; hence, it is surprising that the initial policy response to HIV was so slow, narrow and half-hearted. One set of explanatory factors focuses on the lack of political will and incentives for policy change. Another highlights Botswanan society's denial, secrecy and stigmatisation regarding the disease.

The societal context was one where AIDS was seen as a disease affecting homosexuals in the West, and people from other African countries. There was a real sense of stigma about the disease. By 1997, only seven people had come out in the public sphere as HIV-positive, increasing to 12 by 2002. More have since come out with their HIV statuses, but stigma remains high. There is still a critical need to make testing widespread and accepted.

The first educational campaign in 1988 (which took place at the same time as the first Ugandan campaign) was met with widespread disbelief, as the local evidence did not match the message. The use of condoms, which was the mainstay of the early programmes, went against the views promoted by parents, churches and communities. There was a disconnect between the message from the government and that of traditional faith-healers, many of whom saw natural sexual and blood flows as healthy (Heald, 2002).

Even in the late 1990s, the government response was seen as inadequate. A UNDP Botswana Fact Sheet notes (2000):

In 1998, 13 years since the first case of HIV and AIDS was reported, there was no semblance of a coherent government, let alone nationwide, response to the epidemic. The national response was overly health centred and rather unsurprisingly had limited impact. There was widespread denial, misinformation and generally limited understanding regarding the epidemic. The volume of public resources allocated to its

containment betrayed limited appreciation of the implications of HIV and AIDS for the economy, society, households and individuals. Policy and programme responses were thus severely hamstrung by excessive focus on government, especially the Ministry of Health, to the exclusion of other actors.

Hans Pedersen⁶ offers an interesting insight to explain the slow response and lack of policy change, arguing that during the 1990s, unless HIV/AIDS had a measurable impact on GDP growth and unless it was part of the National Development Plan, the government was unwilling to commit funds towards it. HIV/AIDS was not perceived to impact on GDP growth (until it was too late), and nor was it a part of the National Development Plan (partly owing to the socio-cultural factors mentioned above). The overriding fact is that the government takes great pride in the country's high economic growth rates, savings and budgetary surplus. Botswana is the only African country that is a net contributor to the IMF and WB, and it is run on rather strict financial indicators. Therefore, to analyse and understand the response in Botswana, one must consider it in the context the government perceived all its policy issues: within the macroeconomic context.

The government was eventually persuaded when it began actually to witness that HIV was halting and reversing all development gains. Pedersen argues that the UNDP played an important role: the report UNDP commissioned the Botswana Institute for Development Policy Analysis (BIDPA) to undertake showed a grave impact of HIV on the health and education sectors and huge demographic impact. However, a senior official from the HDR office had to fly in to meet the head of the Botswana Central Statistics Office (CSO) in order to persuade it of its importance, against widespread denial. The Botswana Human Development Report (HDR) proved to be of special importance since it built on these reports but was actually executed by BIDPA. BIDPA is very strong on macroeconomic studies and has close ties with CSO, Bank of Botswana (BoB) and Ministry of Finance and Development Planning (MFDP). The reports all show a grave impact of human development but only a modest impact on GDP growth rates, because Botswana had high unemployment and a capital-intensive mono-economy (diamonds). Furthermore, the BHDR challenged the government to provide ARVs, but did not provide cost estimations. A study headed by the Deputy Governor of the Bank of Botswana confirmed that ARV prices were too high for Botswana to provide treatment for all but, if and when prices come down, it could be done.

Pedersen essentially argues that the policy response in the case of Botswana was slow because of a failure on the part of the government to see beyond a purely macroeconomist way of thinking and developing policy. Institutional inertia and a planning view meant that the government was set on achieving the goals set out in its development plans, and evidence proving that HIV was halting and reversing these goals was only believed once Botswana actually witnessed it, when the country held the world's highest prevalence rate. Botswana's case provides the ultimate proof that political leaders must understand the science in order to change policy, and also confirms Putzel's conclusion (2003) that: 'Waiting to take action on HIV/AIDS until there is evidence of AIDS-induced deaths, will allow the virus to reach epidemic proportions.'

The decision to call HIV/AIDS a national catastrophe in 2000 can be seen in this context, because it opened up the allocation of funds not earmarked in the National Development Plan; this meant tapping into Botswana's huge foreign reserves, which the government has done only very reluctantly; this explains Botswana's good economic governance.⁷

Another factor highlighted by Pedersen is organisational inertia. A culture and tradition of hierarchies exist in Botswana, and there are few skilled people, with power highly centralised and concentrated. In this way, change in policy can only come from above and out of perceived absolute necessity. This change then travels slowly down through the system. However, once policy change has occurred, implementation is carried out effectively.

Consequently, in July 2000, the Botswanan government entered into a massive public-private partnership with Merck and Co. and the Bill and Melinda Gates Foundation. Financial resources and expertise from Merck and the Gates Foundation were brought in to complement and strengthen government initiatives to combat the disease. The African Comprehensive HIV/AIDS Partnership

⁶ Hans Cujus Pedersen, Poverty Advisor, UNDP, Botswana, personal correspondence.

⁷ Hans Cujus Pedersen, Poverty Advisor, UNDP, Botswana, personal correspondence.

(ACHAP), as the initiative came to be known, set out to make Botswana a shining example of how HIV/AIDS might be overcome by combining the best of private and public sector approaches. There had been several criteria behind the decision to channel these resources (US\$100 million over five years) towards Botswana, rather than any other country: most importantly, Botswana had the world's highest HIV rate; moreover, recently re-elected President Festus Mogae was seen as possessing both the power and the motivation to engage with this PPP project (Distlerath and Macdonald, 2004).

Buoyed by the launch of ACHAP, in February 2001 President Mogae further announced that the government would become the first country in Southern Africa with a national programme offering the total package of comprehensive care through the public health system, including the provision of drugs for opportunistic infections and treatment with antiretrovirals (UNAIDS, 2003). The Masa ('new dawn') antiretroviral programme was set up with free drugs provided by Merck, and the *pro bono* services of private management consultants at McKinsey & Co. A great deal of attention has been placed on implementation. Because of the scarcity of health professionals in Botswana, key personnel were recruited from abroad.⁸ They are 'embedded' within Botswana's health services rather than in isolated islands, and their brief is to help to build up local capacity.

Nevertheless, evidence regarding the effectiveness of the Masa programme has been mixed. On the one hand, drug regimen adherence rates are very high. But on the other hand, Masa has not yet been as successful as first hoped. Of the 300,000 HIV-infected people, 110,000 were estimated to meet the criteria to qualify for treatment. The government aimed to enrol 19,000 people in the first year, but only 3,500 were actually enrolled. This disappointing outcome has highlighted a number of issues related to providing antiretroviral therapy in Botswana, including education and training of healthcare workers and strength of infrastructure. It also reflects the ongoing stigma surrounding the disease.

Evidence

From 1985, when Botswana's first AIDS case was reported, mechanisms were slowly put in place to generate evidence on the disease. In 1989, surveys of donated blood revealed that HIV prevalence had risen to 3.35% from 0.93% in 1987 (UNAIDS, 2000). However, it was not until 1992 that the first annual national sentinel surveillance studies began. The extent of HIV was known to the government at this time – particularly the Ministry of Health. There were some initial studies in the mid-1990s trying to map the impact of HIV for the country, but it was not until 2000 that credible studies on the impact of HIV in Botswana began to emerge – by BIDPA and, of course, UNDP. As suggested above, several commentators note the importance of the UNDP Botswana HDR which focused on HIV/AIDS.

In sum, there was evidence about the existence of HIV in Botswana – and this was known to policymakers. But there was not a sufficient body of local evidence about the nature of the disease and its impact: the evidence that did exist was perhaps not communicated in an appropriate way to filter through to the narrow context in which Ugandan policymakers analysed issues.

Links

CSOs

There has historically been minimal involvement of local groups and religious groups in the response to HIV/AIDS. The government has taken a controlling approach rather than the wide engagement seen in Uganda. In addition, one party dominates Botswana politics, undermining the democratic process and possible advocacy channels in parliament. The CSO community have struggled as a consequence of many donors leaving when Botswana obtained the status of a middle-income country. In this way, effective opposition and free press to push the case of HIV/AIDS were, and perhaps are, non-existent.⁹

However, there have been some notable efforts at non-governmental public action in Botswana. One example is the Men, Sex and AIDS Project, run by the Botswana National Youth Council (an NGO), designed to help men talk more openly to each other about sex. Local culture provides little opportunity for serious talk between men about their own sexual experiences. The main reason for

⁸ It is believed many of these came from poorer African countries, e.g. Malawi, Zambia and Tanzania, exacerbating the impact of the epidemic in those countries (Sue Lucas, Personal Communication).

⁹ Hans Cujus Pedersen, Poverty Advisor, UNDP, Botswana, personal correspondence.

targeting men was because they traditionally dominate women in sexual matters and have a responsibility as role models for boys.

Another is the partnership the Botswana Christian AIDS Intervention Programme (BOCAIP) is establishing with ACHAP. The aim is to establish additional counselling and testing centres throughout Botswana. The centres have reached over 70,000 attendants in their community mobilisation and outreach activities so far, and have trained over 400 counsellors.

Media

Although the press in Botswana is free, there exists an inhibiting and strong culture of self-censorship and nationalism. The press fuelled the popular view of HIV/AIDS as a homosexual disease and one that came from foreigners. Social behaviours are restricted in Botswana; for example, it is illegal to practise homosexual sex. Newspapers face repercussions if they print something 'controversial', since the government controls most of the economy through contracts and patronage. As Pedersen highlights, 'this is a very powerful signal, not missed by many in the subtle Botswana consensus culture'.¹⁰

Private sector

Debswana, the key economic actor of significance in Botswana, started rolling out an ARV programme for its employees and their spouses from 2001, because the company were 'afraid of losing key staff'. This is interesting since the company, jointly owned by De Beers and the Botswana government, is considered to have significant influence over the governing of the country. Literature suggests that the role of Mr Louis Nchindo, the then CEO, was very influential in the change in national HIV/AIDS policy (as it is in most policy spheres).

External influences

External influences did enable those in Botswana to become aware of HIV – as it became increasingly noticeable in the West and other African countries. While many external donors are currently active in Botswana on HIV issues (WHO, UNDP, UNAIDS, UNICEF, World Bank, UNFPA), there was very little external impact on national research-policy processes until the late 1990s. Botswana had obtained lower middle-income status, and most donors had left the country when HIV/AIDS became an issue. The only active donors were DFID with a small portfolio and the UN, with USAID mostly active on a regional basis.¹¹ According to Pedersen, it was the UN system that was the primary driver of policy change on HIV/AIDS.

The decision of Merck Company Foundation and the Bill and Melinda Gates Foundation to engage with the Botswana government in the large-scale ACHAP programme, launched in July 2000, was also crucial in facilitating this policy change. It is interesting to note that Donald de Korte, former Merck executive, reportedly took on the post at ACHAP after being encouraged by Nelson Mandela to contribute more to Africa's future (Grunwald, 2002). This started with the development and implementation of a comprehensive HIV/AIDS strategy in Botswana and included free access to antiretroviral treatment in the public health sector. The programme aims significantly to advance HIV/AIDS prevention, healthcare access, patient management and treatment of HIV in Botswana. The Bill and Melinda Gates Foundation and the Merck Company Foundation each committed US\$50 million over five years towards the project, and Merck & Co. is also donating two antiretroviral drugs. The current ARV programmes are 70% funded by the Botswana government, 10% by Gates, 10% by Merck and 10% by other donors.

In addition, Botswana has received the first instalment of P44 million (approximately US\$9 million) from PEPFAR, the US President's Emergency Plan for HIV/AIDS Relief, which should substantially booster the government's efforts in training programmes, stigma reduction activities and assistance to Botswanan NGOs involved in the HIV/AIDS effort.

Future challenges

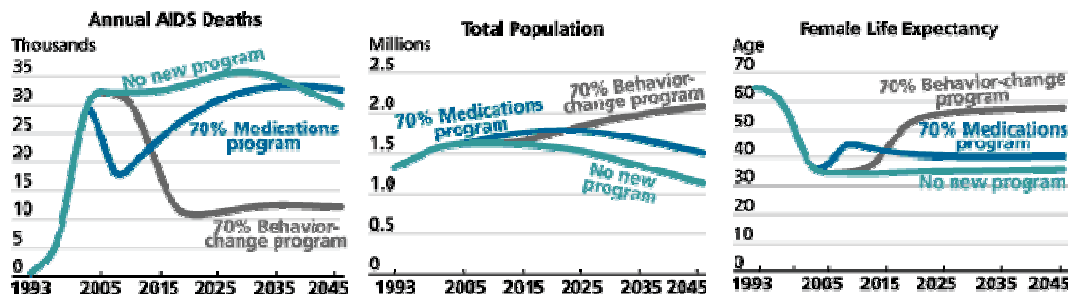
Tough questions remain for Botswana. There is concern that the massive treatment programme may encourage complacent behaviour regarding transmission risks; some patients may not adhere to the strict daily regimen involved in taking the drugs, and so may hasten the development of new

¹⁰ Personal Communication with Hans Cujus Pedersen.

¹¹ Personal Communication with Hans Cujus Pedersen.

medication-resistant strains of the virus. There is also concern that an expensive medication programme may crowd out preventative or behaviour-change resources. Tarmann (2002) has concluded that, in the long run, implementing a modest medication programme while emphasising education that promotes behaviour change is probably the best approach, although many people now living with AIDS will not be around to see its merits. Figure 4 below graphically demonstrates this.

Figure 4: AIDS projections for Botswana, by type of intervention, 1993-2046



Source: Sanderson (2002).

Being the first country in Africa to commit to the widespread distribution of antiretroviral drugs through its public health system, there are important issues for other countries to consider. The first is cost. According to Botswana's government, antiretroviral treatment for the nation's HIV-positive residents will cost about US\$500 million over the next five years (reported in 2002 in the Wall Street Journal). In addition to the availability of antiretroviral drugs, considerable emphasis needs to be placed on health systems (both people and infrastructure). It will be difficult for many countries to match the coverage and high standards in Botswana, but there may be a 'good enough' standard that can be developed.

Conclusion

With a highly centralised government, and a lack of effective civil society and press freedom, it was down solely to the government to change policy on HIV/AIDS. However, organisational and institutional inertia meant the government only responded once hard evidence showed that the epidemic was impacting upon an issue close to its heart and the very centre of its legitimacy: the economic and national development sphere. The remaining donor community, particularly the UN, was largely responsible for pushing HIV/AIDS onto the political agenda. The UN's influence was delayed owing to the government's inability to see beyond a purely macroeconomic context; however, it was helped when the national body BIDPA had a large role to play in the Botswana HDR. BIDPA had closer and more legitimate links with the all-important policymaking bodies of the MFDP, CSO and BoB.

A large part of the problem was that HIV/AIDS was perceived for too long as a health issue rather than a national development issue, denying any incentive for interest from the most important policymaking body, the MFDP. Pedersen believes the link between poverty and HIV has perhaps still not convincingly been made, which may continue to hamper efforts.

Regarding the roll-out and implementation of national treatment and care programmes, Botswana highlights several important issues. Merck, the Gates Foundation and later PEPFAR have chosen to invest in Botswana for good, evidence-based reasons: Botswana demonstrates political and economic stability and good governance; it has a fairly good health infrastructure; treatment is almost for free; and the country serves a small population that is largely urban-based. In this way, Botswana provides the ideal pilot case to see whether such roll-out can be carried out in Africa (a subject about which many people have serious reservations).¹² However, it equally highlights that such programmes can and should only be carried through following extensive research demonstrating that the country structures are capable of supporting it.

¹² Personal Communication with Hans Cujus Pedersen.