

Highlights

Botswana has been one of the countries hardest-hit by the HIV/AIDS epidemic, since the first case was detected in 1985. However, there has been a determined national response, including the provision of free anti-retroviral therapy (ART) through the public health service from an early stage, as well as attention to prevention programmes, including the prevention of mother-to-child transmission (PMTCT).

Unlike many countries in sub-Saharan Africa, the majority (around 60 percent) of the cost of HIV and AIDS programmes has been met by government, with the remainder financed by donors, notably the US government (PEPFAR), the Merck Company Foundation, and the Global Fund. HIV and AIDS programmes are the only area where Botswana receives significant donor support.

There has been considerable progress in containing HIV and AIDS, and epidemic control is now within reach. From a public health perspective, there have been major successes. Nevertheless, the fiscal cost has been high, and the fiscal costs of HIV / AIDS programmes account for around 2 percent of total government spending, with indirect costs (e.g. health staff costs) perhaps a further 1 percent.

As with other areas of government spending, the availability of financing is not the primary constraint; instead there have been challenges in spending available funds, and significant donor funding allocations have been returned unspent. Hence there are institutional capacity issues.

The Government introduced a “Treat All” programme in 2016, whereby all citizens who test HIV positive are immediately put on ART. The expectation is that the higher initial cost of this approach will lead to medium-term benefits through faster epidemic control, fewer infections, and lower treatment costs.

The Third National Strategic Framework for HIV and AIDS (NSF 3) runs from 2019 to 2024 and plans to have targeted interventions in priority areas, including geographical areas and high-risk population groups.

Investment in HIV and AIDS programmes has helped to bring the epidemic under control, but substantial fiscal resources are still required. This challenge can be met through improved programme efficiency; better data, monitoring and evaluation; and sufficient fiscal allocations to consolidate gains before costs start declining

Key Policy Issues

- ✚ Updated statistics and improved M&E, to ensure that there is an adequate information base for modelling the epidemic, determining key trends, identifying priorities, projecting resource needs and evaluating the impact of interventions and policies. This requires better use of health system data as well as regular national surveys, and fully incorporating monitoring and evaluation into HIV and AIDS programmes.
- ✚ Updating projections of financial requirements for HIV and AIDS programmes on the basis of recent projections of the extent of the epidemic as well as updated treatment costs.
- ✚ Further interventions to bring the epidemic under control, by extending public sector ART coverage to non-citizens, and addressing the priority targets identified under NSF 3. A focus on prevention is necessary to ensure that past gains are consolidated.
- ✚ Improving programme efficiency to address organisational inefficiencies in the administration of AIDS and HIV programmes, which affect both the effectiveness of spending as well as access to donor funds. As elsewhere in government, identifying the sources of inefficiencies and addressing them so as to get improved value for money is a high priority.
- ✚ The likely reduction of donor funding in the coming years means that additional budgetary allocations of around P0.5 billion a year will be needed to ensure that the full range of HIV and AIDS programmes are maintained.

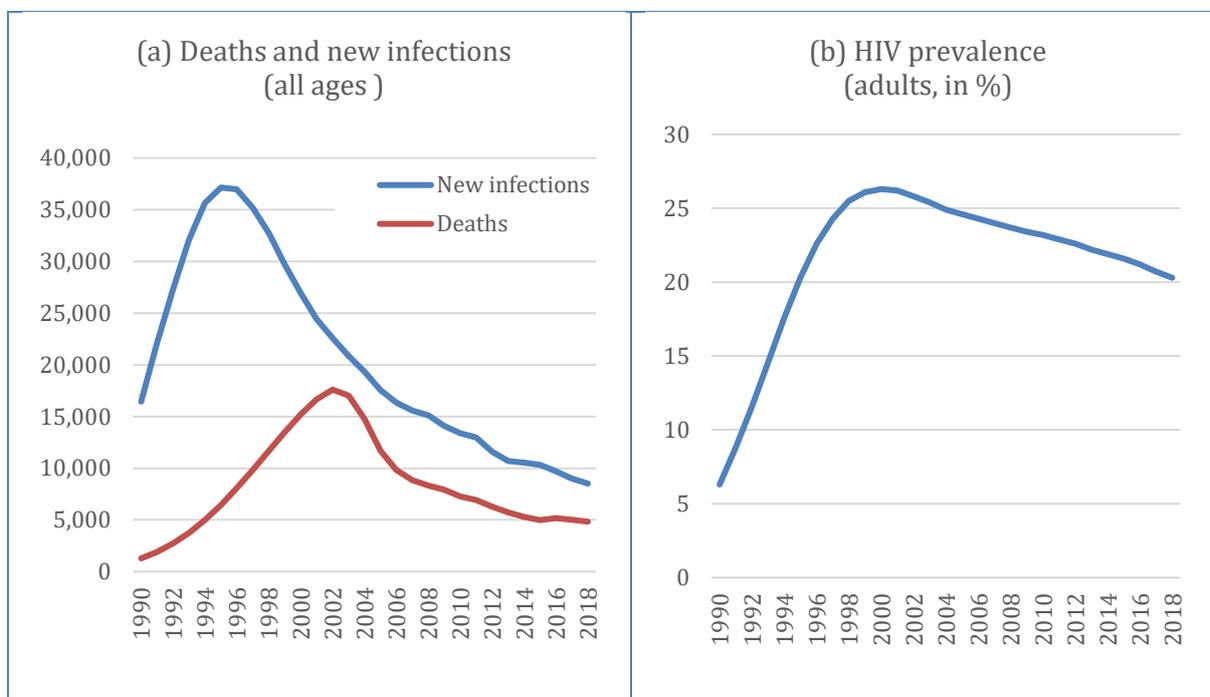
Section 1. Introduction

1.1 HIV and AIDS Overview

The first cases of HIV in Botswana were detected in 1985. Over the next few years the epidemic spread rapidly and reached a peak in 1995 when the number of new infections reached an estimated 37,145¹. The number of HIV-related deaths peaked a few years later, at 17,598 in 2002. Since that time, both the number of new infections and the number of deaths has dropped dramatically, by an estimated 77 percent and 73 percent respectively. By 2018, an estimated 370,000 people were living with HIV, an adult prevalence rate of 20.3 percent².

The Government of Botswana reacted rapidly to the emergence of HIV/AIDS as a public health issue. For several years, Botswana had the highest adult HIV prevalence rate in the world, and the disease threatened to wipe out a large proportion of the population and cause huge economic and social disruption. The response included establishing the National AIDS Co-ordinating Agency (NACA), under the Office of the President, to – as its name implies – co-ordinate HIV/AIDS-related activities. These cut across a number of government departments as well as non-government organisations (NGOs) and development partners, hence the need for co-ordination of activities and centralisation of funding. Botswana introduced free anti-retroviral treatment (ART) through the public health service in 2002, as well as prevention initiatives and household-based orphan care. Besides rolling out testing and treatment, one of the main priorities was the Prevention of Mother-to-Child Transmission (PMTCT). The success of these programmes is shown by the drop in the number of new infections and deaths. In 2016 the Government introduced a “Treat All” or test and treat strategy, in which everybody who tests positive for HIV is offered immediate ART, regardless of their viral load.

Figure 1: Key HIV trends



Source: UNAIDS Aidsinfo <http://aidsinfo.unaids.org/>

¹ <http://aidsinfo.unaids.org/>. These data are based on the official Spectrum 2019 projections.

² <http://aidsinfo.unaids.org/>

Botswana remains among the top 4 countries in the world ranked by adult HIV prevalence (after Eswatini, Lesotho and South Africa) – although a persistently high prevalence rate may be an indicator of a successful treatment programme rather than policy failure³. Heterosexual intercourse is the most common source of transmission of the virus. However, HIV prevalence varies across high-risk population groups. While the general adult population has an HIV prevalence rate of 20.3 percent, for Female Sex Workers (FSWs) HIV prevalence was estimated to be 42.2 percent, while for men who have sex with men, prevalence was estimated to be 14.8 percent in 2018⁴.

1.2 Policies, Strategies and Institutions

Policy responses

Botswana responded quickly to the emergence of HIV/AIDS. The first response was the 1987 – 1989 Short-Term Plan of Action; followed by the First Medium Term Plan 1989 – 1993; the 1997 – 2002 Second Medium Term Plan; and a National HIV/AIDS Policy in 1993.

Both the Short-Term Plan and the First Medium Term Plan were largely clinical responses to the HIV and AIDS situation, with less emphasis on public awareness and information campaigns. They lacked sufficient quality and coverage. The development of the second Medium Term Plan for 1997 – 2002 recognised the need to go beyond the limitations inherent in the previous plans by providing a platform for a multi-sectoral national response, including treatment, prevention, public information, and social care and protection. It also established co-ordination structures such as the National AIDS Council (NAC), National AIDS Coordinating Agency (NACA), District Multi-sectoral AIDS Committees (DMSACs) and Village Multi-sectoral AIDS Committees (VMSACs). Significant programmes such as ARV Therapy, home-based care and family-based care for orphans and vulnerable children were launched as part of the national response to mitigate the impact of the HIV and AIDS epidemic. HIV voluntary counselling and testing was introduced, and the first Botswana AIDS Impact Survey (BAIS I) was conducted in 2001.

Building on the lessons learnt from the implementation of the MTP II, the First National Strategic Framework for HIV and AIDS (NSF-I) was developed for 2003-2009. NSF-I addressed the weaknesses that were becoming evident in national responses across Africa, such as lack of focused and coordinated implementation, weak management of the national response, inadequate legislative and policy environment, and insufficient strategic guidance for implementing sectors. It was aligned with the Ninth National Development Plan (NDP9) in order to emphasize the longer-term development aspects of the epidemic and to promote mainstreaming of HIV and AIDS into national development planning and budgets.

The Second National Strategic Framework for HIV and AIDS covered 2010-2016. NSF-II generally aimed to build on the successes that had been achieved over the previous two decades, and to address identified weaknesses. NSF-II had four priorities: (i) Preventing New Infections; (ii) Systems Strengthening; (iii) Strategic Information Management; and (iv) Scaling Up Treatment, Care and Support.

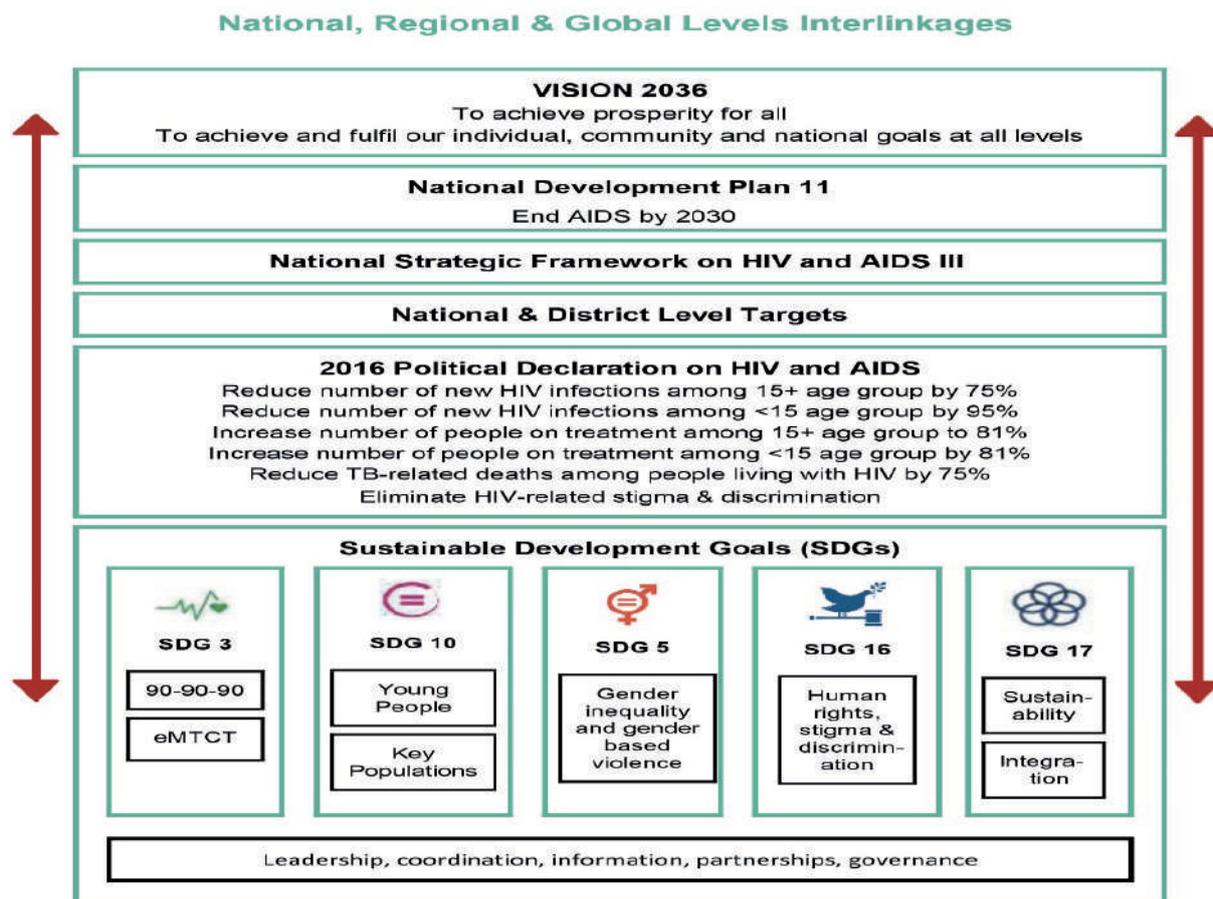
The Third National Strategic Framework (NSF-III) covers the period 2019-23 and has again updated the approach to dealing with the evolving challenge from HIV and AIDS. NSF 3 takes the view that the HIV epidemic has evolved from being a generalised epidemic to a series of micro-epidemics affecting different populations in different ways. It proposes modification of strategies

³ Interestingly, Botswana is not included in the Top 25 countries in the world with the highest numbers of new infections under the UNAIDS "HIV Prevention 2020 Roadmap"

⁴ <http://aidsinfo.unaids.org/>

to address the increasingly varied burden of HIV across different populations and settings. It also establishes specific targets related to achieving epidemic control by 2023 and ending AIDS as a public health threat by 2030. It involves shifting from a national approach to priority geographic locations and populations based on evidence. It also involves giving prevention greater priority, with a commitment to increasing spending on prevention from 5 percent of total spending to 25 percent⁵. NSF-III proposes moving from 90-90-90 to a 95-95-95 treatment cascade target and achieving this by 2023. Finally, NSF-III is integrated into national and international strategies, as shown below.

Figure 2: NSF-III Linkages to National and International Strategies



Source: NSF-III, p.14

Institutional Structures

NACA was established in 1999 to co-ordinate the multi-sectoral response to HIV and AIDS. NACA’s role reflected the multi-faceted and cross-cutting nature of HIV/AIDS programmes, requiring a wide-ranging co-ordinating role. Its original functions included everything from strategic planning and policy formulation, mobilisation of funding and working with donors and development partners, management of treatment, prevention, and social mobilization. NACA fell originally under the Office of the President, and its budget included funding for all of these activities, including treatment and the roll-out of ARV programmes. It was later moved to the Ministry of Health and Wellness (MOHW) (in 2015) to avoid fragmentation of the clinical and

⁵ NSF-III, p.18

public health response to HIV and AIDS. More recently, NACA has been restructured to focus on prevention and education, but with a broader mandate to deal with health promotion more generally, given the increasing importance of non-communicable diseases such as cancer and diabetes. It has been renamed the National AIDS and Health Promotion Agency (NAHPA).

Responsibility for the implementation of HIV/AIDS programmes is shared between a variety of different government agencies and civil society organisations, with those responsibilities changing over time. The MOHW has been responsible for treatment through the public health service. The Ministry of Local Government and Rural Development (MLGRD) is responsible for Community Home-Based Care (CHBC) and Orphans and Vulnerable Children (OVC) support. Private medical services provide treatment to those enrolled in medical aid schemes (about 15 percent of the population). Various civil society organisations (CSOs) are also involved in HIV/AIDS programmes, including the Botswana Business Coalition against AIDS (BBCA), the Botswana Network of People Living with AIDS (BONEPWA), the Botswana Network of AIDS Service Organizations (BONASO), the Botswana Christian AIDS Intervention Programmes (BOCAIP), and the Botswana Network on Ethics, Law and Human Rights (BONELA). Important development partners include UNICEF, UNFPA, UNDP, UNAIDS, the African Comprehensive HIV/AIDS Partnerships (ACHAP), PEPFAR, and BOTUSA/CDC. Tebelopele (a partnership between the Botswana and USA Governments) provides the largest network of voluntary HIV counselling and testing (VCT). There are a number of research initiatives, including the Botswana-Harvard AIDS Institute Partnership (BHP), which goes back to 1996.

1.3 Sector Performance and Challenges

As noted above, there have been considerable achievements in addressing HIV and AIDS in Botswana, with declining numbers of new infections, deaths and prevalence: a 36% reduction in the number of new HIV infections between 2010 – 2018, and a 40% reduction in AIDS related deaths over the same period. Vertical transmission (mother-to-child) has been reduced to very low levels⁶. In 2018, over 90 percent of those with HIV knew their status; over 83 percent of those living with HIV were on ART; and 81 percent of living with HIV were virally suppressed⁷. Botswana is therefore close to achieving the 90-90-90 targets for the WHO HIV Testing and Treatment Cascade. On one of the key indicators of epidemic control – the incidence-prevalence ratio – Botswana achieved an estimated level of 2.3 percent in 2018, well below the international target of 3.0 percent, indicating that Botswana is on the path to ending the AIDS epidemic⁸.

Despite these achievements, several challenges remain. The number of new infections needs to be reduced further to achieve epidemic control (defined as the number of infections falling below the number of deaths). There are also major gender imbalances; for instance, the prevalence rate for women (24.6 percent in 2018) is much higher than for men (16.2 percent)⁹, and young women are particularly at risk. There are also significant geographical variations in prevalence, ranging from 33 percent of adults in Mahalapye to 13 percent in Hukuntsi. In general, prevalence is higher in North-East Botswana, but apart from this prevalence does not follow any clear geographical pattern.

A further challenge is co-infection: many people living with HIV and AIDS (PLWHA) are also infected with tuberculosis (TB), and many deaths amongst PLWHA are from TB. Treatment regimens therefore need to address the need to deal with this co-infection. As elsewhere in the

⁶ UNAIDS data (2018) reports that the number of new HIV child infections is less than 500 a year, compared to a peak of almost 6,000 in 1998. The final MTCT rate (at end of breastfeeding) is 2.5%. Coverage of pregnant women who receive ART for PMTCT is almost 100 percent.

⁷ UNAIDS Botswana Country Factsheet, 2018

⁸ UNAIDS (2019) Global AIDS Update, p.32

⁹ UNAIDS Botswana Country Factsheet, 2018

Botswana public sector, there are systemic inefficiencies. This is reflected in operational problems, such as shortages of drugs in the public health system, and spending problems.

There is also a lack of high-quality data on HIV and AIDS. Some key metrics (e.g. prevalence) are only directly measured infrequently, through nationwide surveys. Other metrics (e.g. incidence/new infections) cannot be measured directly and must be inferred. Some measures (e.g. prevalence amongst pregnant women) relate to specific populations and cannot easily be extrapolated to the entire national population. In this situation, data are derived from modelling and simulation tools, such as Spectrum, that are calibrated to actual data. The main source of data is the Botswana AIDS Impact Survey (BAIS), a national household survey carried out by Statistics Botswana. Four BAISs have been carried out, in 2001, 2004, 2008 and 2013. There is now a six-year gap since the last BAIS, and hence the statistical basis for making modelled estimates of prevalence, infection and death rates is weak.

Takeaways:

- HIV/AIDS is a major public health issue in Botswana and has generated a widespread and large-scale response that has helped to effectively address the epidemic.
- An effective coalition of government, development partners and civil society organisations has been involved in the response to HIV and AIDS.
- The third National Strategic Plan, 2019-23 focuses on targeted interventions to deal with the needs of specific groups and populations.
- New HIV infections and AIDS deaths have dropped dramatically following widespread roll-out of treatment through the public health system, although epidemic control has not yet been reached.
- Since 2016, all those testing HIV-positive are immediately enrolled in the Anti-retroviral therapy (ART) programme

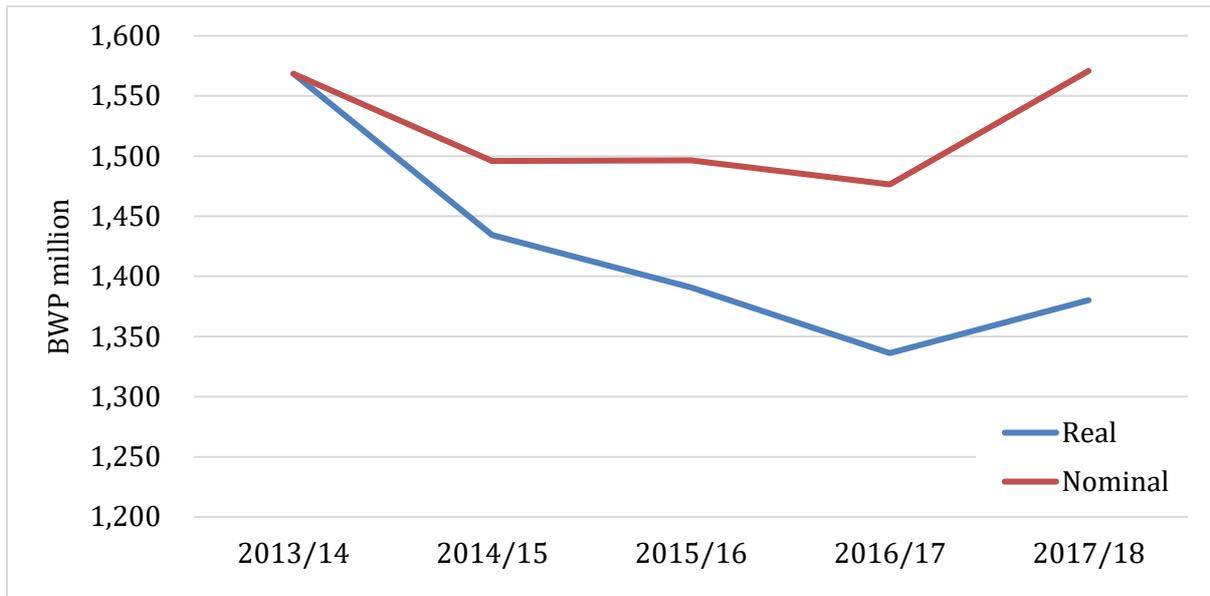
2. Level and Composition of HIV and AIDS Spending

It is not easy to estimate what is spent in total on HIV and AIDS. Spending is reported quite well on a number of direct expenditure items, but indirect spending, for instance on general in-patient and out-patient care for HIV patients, is not included. In the government budget, HIV-related spending falls under a number of different agencies, but primarily the MOHW, MLGRD and NAHPA. There have been important changes in where HIV and AIDS spending appears in the budget – for instance with the movement of NACA from OP to MOHW and back again, and the movement of ART drugs and laboratory costs from the Department of AIDS Prevention and Care to the Department of Clinical Services within MOHW, which makes tracking more difficult. Expenditures have also been shifted between the development and recurrent budgets over the years. Nevertheless, detailed information on spending has been provided by NAHPA in their “Analysis of HIV Investment in Botswana”, May 2019.

2.1 Total HIV/AIDS spending

Data on HIV/AIDS spending is available until 2017/18. The data shows that total HIV/AIDS spending fell from P1,568 million in 2013/14 to P1,476 million in 2016/17, before increasing to P1,571 million in 2017/18 – essentially unchanged in nominal terms over the period. In real terms, however, spending fell by 12 percent over this period.

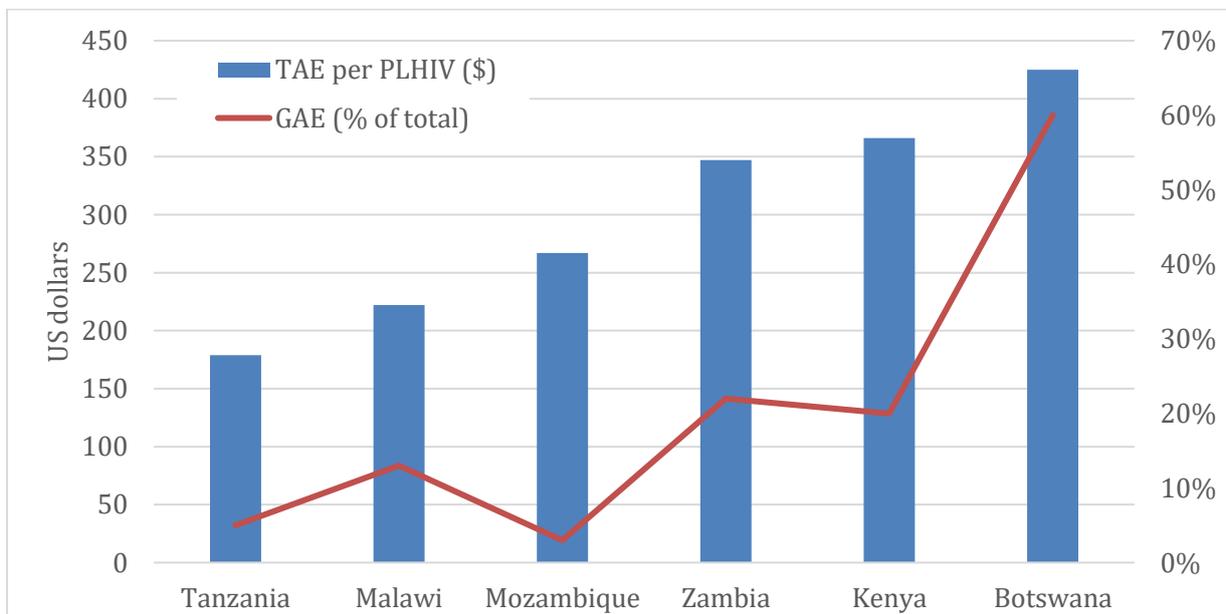
Figure 3: Total spending on HIV and AIDS, real and nominal



Source: NAHPA, Analysis of HIV Investment in Botswana, 2019

HIV and AIDS spending in Botswana is relatively high by regional standards, measured in terms of total AIDS expenditure (TAE) per person living with HIV (PLHIV), at an estimated USD 425 in 2017/18. Spending for other countries in sub-Saharan Africa for which comparable data are available ranges from \$179 (Tanzania) to \$366 (Kenya). What is more striking about Botswana is the high proportion of TAE financed by the government AIDS expenditure (GAE).

Figure 4: Spending on PLHIV in selected countries, various years



Source: NAHPA, Analysis of HIV Investment in Botswana, May 2019 and USAID Health Financing Profiles (<http://www.healthpolicyproject.com/index.cfm?id=sfbriefs>)

2.2 Composition of HIV and AIDS spending¹⁰

Direct spending related to HIV/AIDS is categorised into several different categories.

Table 1: Main expenditure categories for HIV and AIDS programmes

Category	Main items included
Treatment, care and support	Testing & counselling, ART, laboratory monitoring, opportunistic infections (exc. TB), palliative care
Prevention of vertical transmission of HIV	PMTCT
Prevention	Social & behaviour change, condoms, pre-exposure prophylaxis (PrEP), voluntary male circumcision, programmes for high-risk, populations, workplace programmes
Gender programmes	
Programmes for children and adolescents	
Social protection	Support for orphans and vulnerable children (OVC)
Community mobilization	
Governance and sustainability	Strategic information, planning, procurement & logistics, health systems strengthening, education, research
Critical enablers	Policy dialogue, human rights programmes, AIDS-specific institutional development
TB / HIV co-infection, diagnosis and treatment	
Other	

Source: NAHPA, Analysis of HIV Investment in Botswana, May 2019

Over the five years from 2013/14 to 2017/18, total HIV/AIDS spending was P7.6 billion. Just over half of this spending (54 percent) was devoted to treatment, care and support, with most of the remainder devoted to social protection (23 percent), prevention (including prevention of mother to child transmission, PMTCT) (13 percent) and governance and sustainability (8 percent). Under treatment, care and support, the main expenditure items are anti-retroviral treatment (ART) (41 percent), HIV testing and counselling (5 percent), laboratory monitoring (3 percent) and palliative care (5 percent).

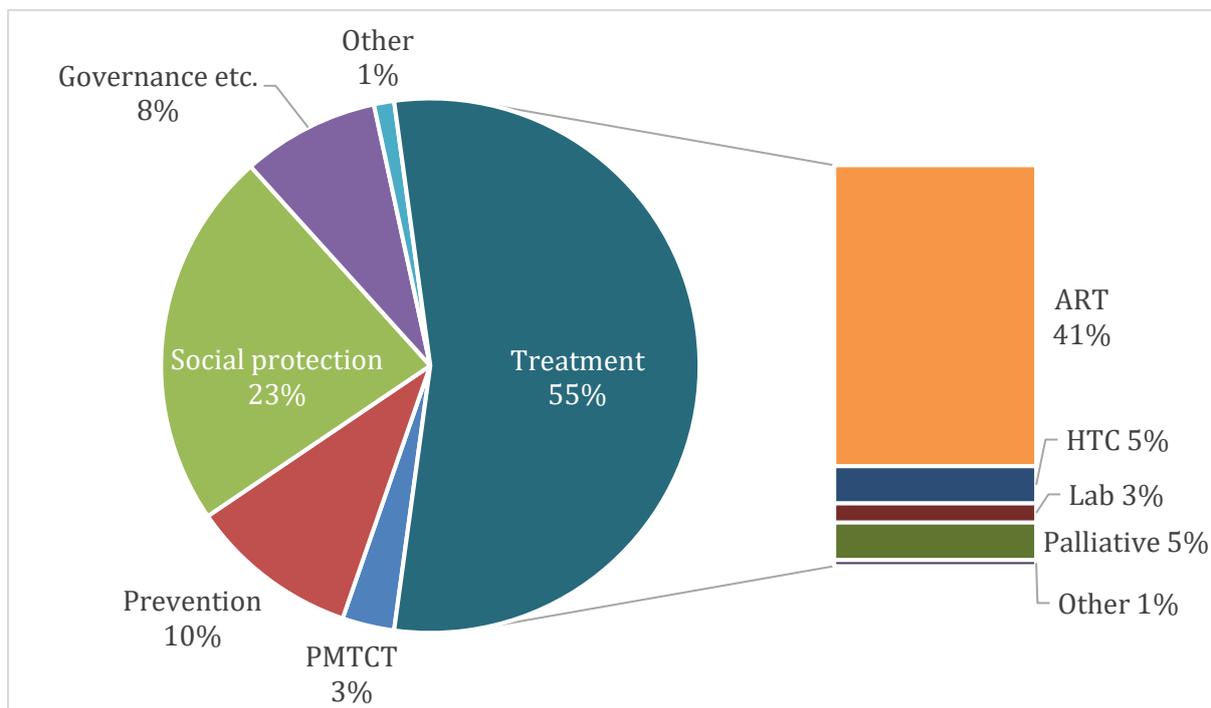
NAHPA wishes to assess how close it is to reaching the international target of devoting one quarter of the total HIV budget for prevention¹¹. This is not entirely straightforward, as the target itself is somewhat qualified (“depending on HIV prevalence and treatment costs”) and there is no clear definition of what is included in the definition of prevention. Direct allocation to prevention

¹⁰ Excluding indirect spending on treatment

¹¹ UNAIDS, HIV Prevention 2020 Roadmap

programmes (Table 1) is only 3.1 percent of total spending, which is far below the international target. However, prevention of vertical transmission (PMTCT) takes up 10 percent of spending. Furthermore, an important justification for the Treat-All programme is that universal ART provision is an effective prevention tool; treatment, care and support take up 54 percent of total spending. The 25 percent international target is somewhat crude and does not reflect individual country circumstances. Meeting the international target would require prevention spending to be increased tenfold, and this is unlikely to be feasible or productive, given that Botswana has taken a different approach (universal treatment) to prevention. Hence the target is of limited relevance to Botswana. Nevertheless, in view of the increased focus on prevention, attention should be paid to whether the five key prevention pillars laid out in the UN HIV Prevention Roadmap are being sufficiently resourced¹².

Figure 5: Composition of HIV-related spending, 2013/14 to 2017/18



Source: NAHPA, Analysis of HIV Investment in Botswana, 2019

Takeaways:

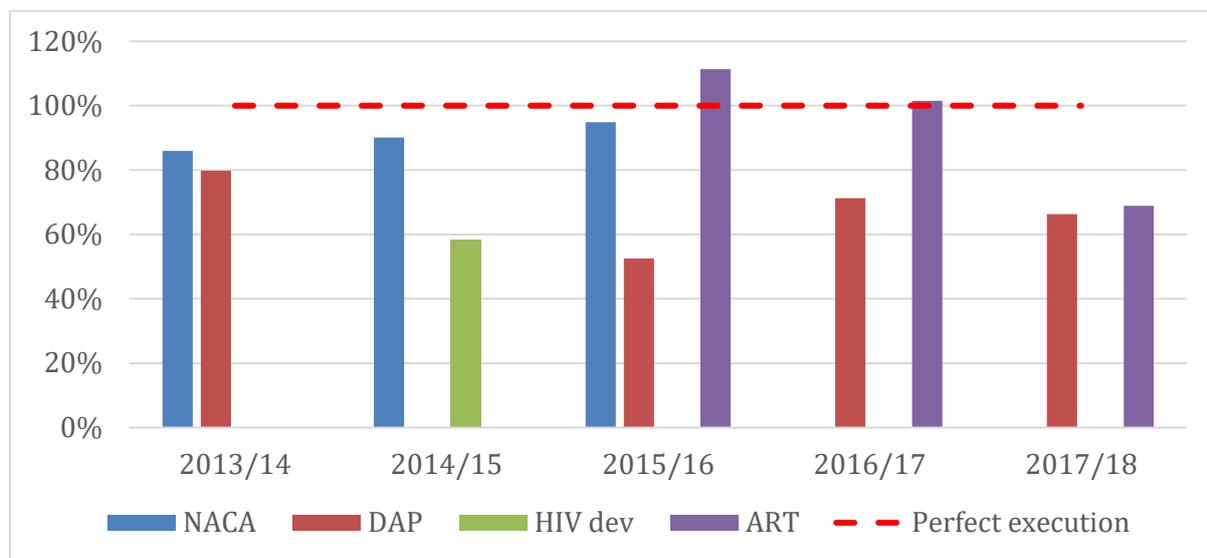
- Due to the extent of the epidemic, a high level of spending has been devoted to HIV and AIDS programmes. However, this has levelled off in nominal terms in recent years and declined in real terms
- Just over half of HIV-AIDS spending is devoted to treatment, care and support, of which the bulk is for ART
- Direct expenditure of prevention is around 3 percent of the total, but PMTCT and a significant proportion of treatment costs can also be classed as prevention, especially since the introduction of Treat-All. Spending on the five key pillars of prevention should be assessed for adequacy.

¹² The five pillars are: (i) Combination prevention for adolescent girls, young women and their male partners; (ii) Combination prevention programmes for all key populations; (iii) Strengthened national condom and related behavioural change programmes; (iv) Voluntary medical male circumcision (VMMC); and (v) pre-exposure prophylaxis (PrEP) to population groups at substantive risk.

3. Budget Credibility and Execution

The presentation of budgetary data on HIV and AIDS spending makes it difficult to explicitly measure budget credibility and execution on an annual basis. This is because of the frequent changes in responsibility for various programmes, and changes in classification of spending, combined with gaps in reporting. Nevertheless, some analysis is possible. Figure 6 shows the efficiency of budget execution (actual spending as a percentage of the revised budget). NACA showed increasing execution efficiency in the years before its transfer from OP to MOHW (at which point it disappeared as a separate budget line). The MOHW Department of AIDS Prevention and Control exhibited relatively low execution efficiency, while ART budget lines were good in 2015/16 and 2016/17 before dropping off in 2017/18.

Figure 6: Budget Execution, various HIV and AIDS programmes



Note: DAP - Department of AIDS Control and Prevention (MOHW); HIV - all development programmes related to HIV and AIDS; ART - budget lines for drugs and laboratory services under the Dept. of Clinical Services, MOHW. Source: Ministry of Finance and Economic Development, Estimates of Expenditure from the Consolidated and Development Funds, various years.

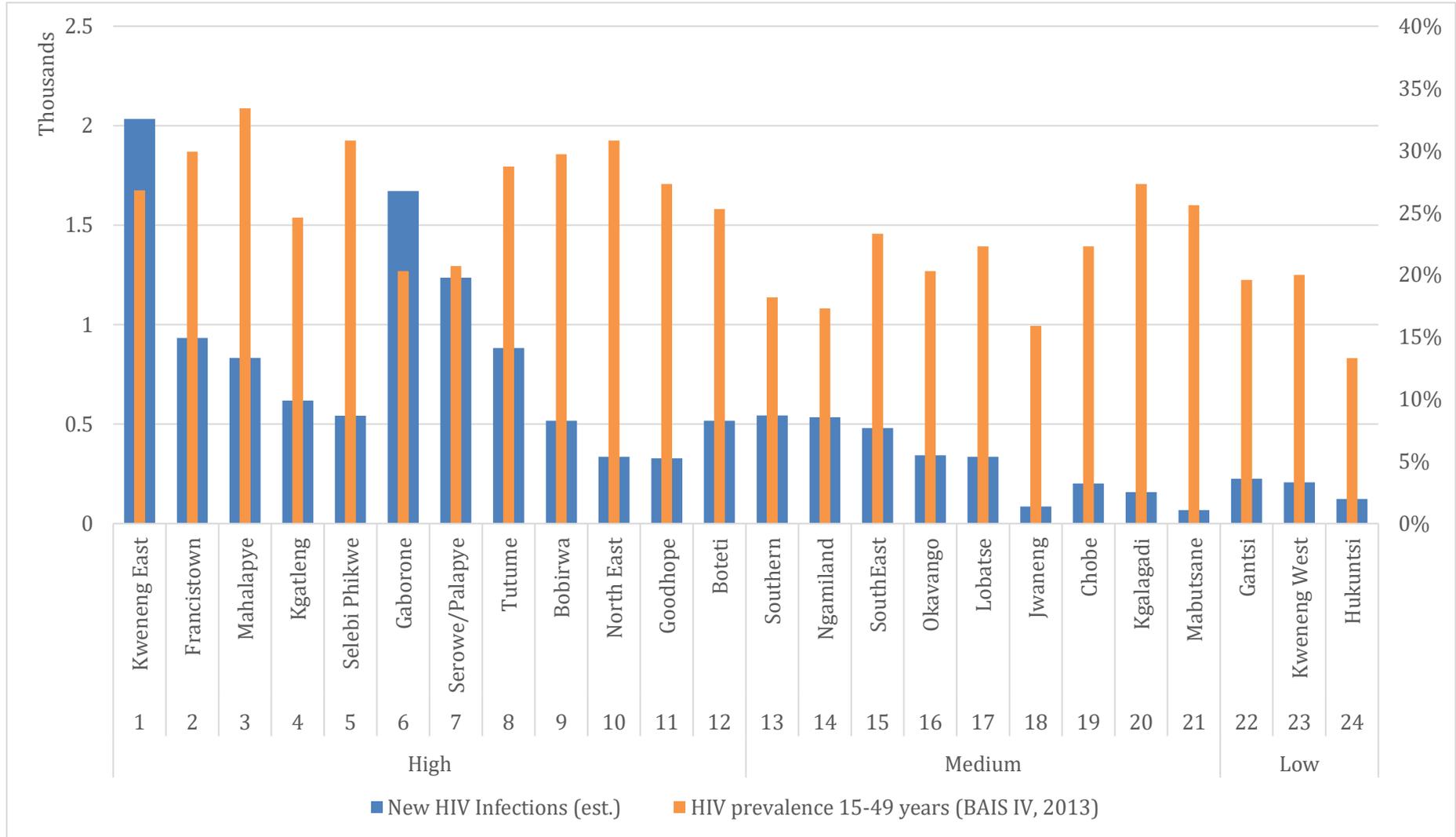
4. Decentralisation and Equity

As noted above there is considerable variation in the extent of HIV and AIDS across districts. To date, this has not been substantively reflected in the distribution of financial resources. However, under NSF-III, with its move to targeted interventions, districts have been ranked into one of three priority groups, depending on the (estimated) number of new infections and the level of HIV prevalence. The prioritisation of districts is shown in Figure 7. The intention is that this ranking will guide the level of investment in HIV prevention programmes at district level. In view of the major differences in the 2019 projections, compared to the 2018 data used in the preparation of NSF-III, it may be necessary to revisit the classification of priority districts.

Other interventions will be guided by the specific needs of different target groups, including those with currently low service coverage. The limited evidence available indicates that HIV prevalence is higher amongst lower income groups¹³.

¹³ World Bank Botswana Poverty Assessment, 2015, p.135

Figure 7: Prioritisation of districts for prevention activities



Source: NAHPA NSF-III

Takeaways

- Changes in the budgetary classification of HIV and AIDS spending make it very difficult to track differences between planned and actual spending, and hence budget credibility. However, where data are available, credibility and execution appear for MOHW budget lines to be weak, although NACA's record was better when it was under the Office of the President.
- Going forward, it is planned to improve the link between the allocation of resources and identified needs

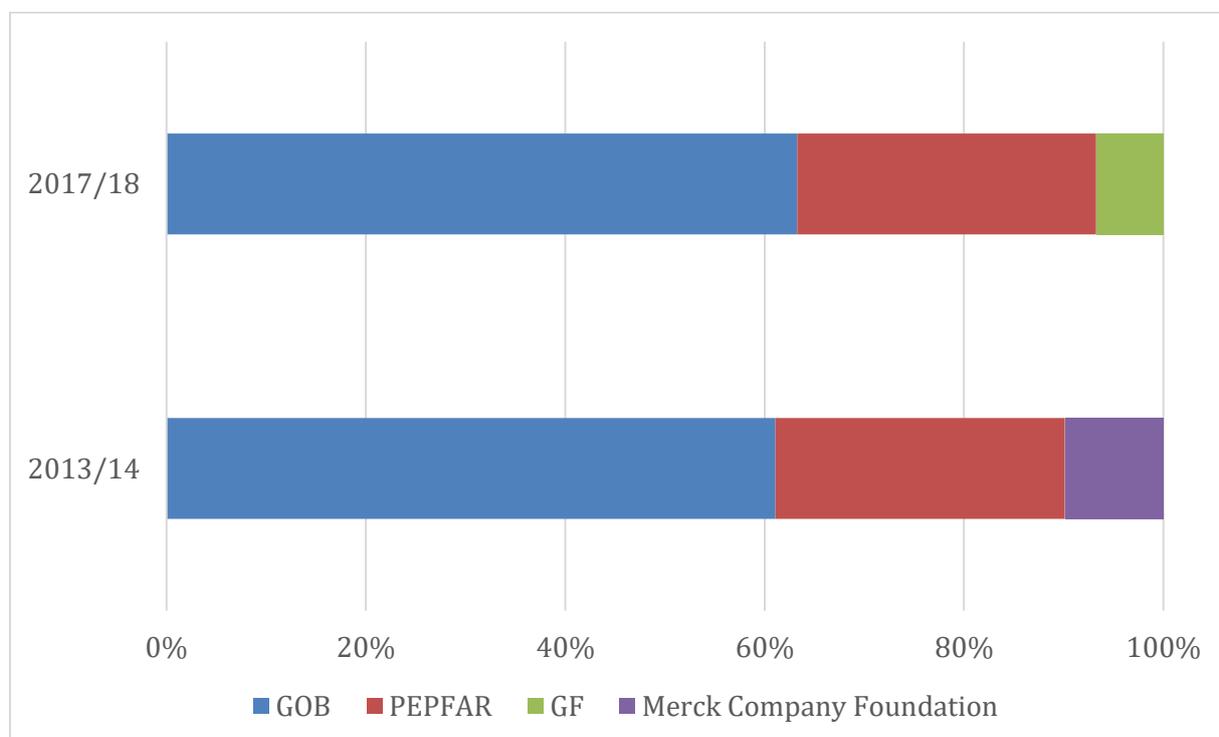
5. Financing of HIV/AIDS programmes

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In contrast to the situation in many poorer countries, the largest share of HIV/AIDS programme financing has come from the Government, through the normal budget allocation process. However, this is one area where donor support has been significant in recent years; whereas donor funding is insignificant in the overall context of the government budget – contributing less than 0.3 percent of overall revenues over the past five years – it makes an important contribution to resources for HIV/AIDS programmes.

The major donors have been the US Government's President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Merck Company Foundation. Over the past five years, donors have in total contributed 36 percent of the cost of HIV/AIDS programmes, comprising PEPFAR (30 percent), Merck (4 percent) and Global Fund (2 percent). However, access to donor funding is changing. The Merck Company Foundation ceased its funding in 2015/16, whereas the Global Fund began funding Botswana programmes the following year, 2016/17.

Figure 8: Financing of HIV-AIDS programmes, 2013/14 and 2017/18



Source: NAHPA, Analysis of HIV Investment in Botswana, 2019

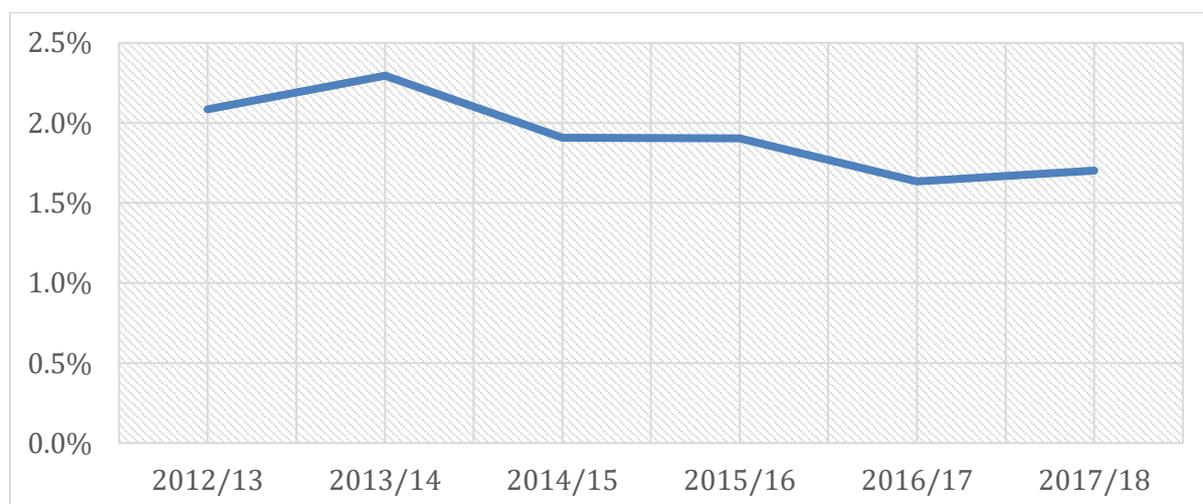
Available data only covers the period to 2017/18. However, indications are that donor funding has declined significantly since that time. Botswana was unable to spend all of its Global Fund allocation up to 2018, and funding was reduced in 2019. Botswana was also unable to spend its PEPFAR allocation in FY2018, utilizing only USD42 million of the approved USD70 million budget¹⁴. Despite this, the PEPFAR allocation was maintained at USD 70 million for FY2019. However, PEPFAR has now proposed a 40 percent reduction in its funding in FY2020, to USD42.5 million¹⁵. While this sounds like a major reduction, the likely impact will be less than the 40 percent headline reduction, given that Botswana was unable to spend the full allocation in recent years. The new allocation of USD42.5 million is close to the levels of actual PEPFAR funded-expenditure in recent years.

5.1 Fiscal Impact and Trends

As noted above, the Government meets just over 60 percent of the direct costs of HIV/AIDS programmes. Fiscal data on spending related to HIV/AIDS includes direct spending falling into the categories listed above (Table 1). Government spending has been stable in nominal terms, in a range of P900 million – P1 billion over the five years from 2013/14 to 2017/18. However, in real terms, spending has been declining, and has fallen by 9 percent from its peak in 2013/14 to 2017/18.

HIV/AIDS spending by government averaged 1.9 percent of total government spending over 2013/14 to 2017/18. The share has been on a downward trend, from a maximum of 2.3 percent in 2013/14, to 1.7 percent in 2017/18.

Figure 9: Government HIV spending as percent of total government spending



Source: NAHPA, Analysis of HIV Investment in Botswana, 2019

5.2 Total resource needs

The introduction of Treat-All (Test and Treat) in 2016 has increased HIV/AIDS programme costs in the short-term, due to the much higher number of patients on treatment. In the longer-term, costs should be reduced, once the impact of higher levels of treatment feeds through to reduced new infections and better health status generally. The Investment Case prepared in 2016¹⁶

¹⁴ PEPFAR: Botswana Country Operational Plan 2018 – Strategic Direction and Summary (March 2018)

¹⁵ Botswana COP19 Planning Level Letter

¹⁶ Botswana Investment Case, 2016: Investment Towards Effective HIV Prevention, Health System Strengthening & the End of AIDS (Govt. of Botswana/UNAIDS).

estimated that Test-and-Treat would increase total costs by some 30 percent in the early years, leading to total costs of approximately P2.5 billion in 2018. This is substantially higher than the P1.5 billion actually spent on HIV / AIDS programmes in 2017/18¹⁷. However, since the Investment Case was prepared treatment costs have been reduced, as drug treatment regimens have changed, and prices have fallen. An updated estimate of total resource needs is now required. This would be based on updated costs as well as epidemiological projections (e.g. from an updated Spectrum model), reflecting more recent data on testing, treatment, demography etc. The beneficial impact of successful treatment programmes has already been seen in the declining number of orphans in Botswana, and hence lower welfare programme costs.

5.3 Financing gap

Without an updated resource needs assessment, it is not possible to derive a current or future financing gap relative to total projected needs. However, it is feasible to identify the financing gap that would arise from the anticipated gradual winding down of donor support. In the long term, we can assume that the one-third of HIV/AIDS programme costs met by donors will be phased out and will need to be met by government. This would increase the required Government of Botswana contribution by 50%. Relative to 2017/18 spending levels, this would require Government of Botswana to increase its allocation by P577 million a year, or approximately 1 percent of total Government of Botswana spending¹⁸. This may not appear to be much in the context of the overall government budget, but it comes at a time when the overall expenditure budget is under pressure due to declining revenues. Hence, increased allocations to HIV/AIDS will be competing with other claims on the budget, and with other priority areas trying to maintain their budgets while overall spending is falling as a share of GDP.

Some countries have attempted to protect budgets for HIV/AIDS programmes by establishing dedicated revenue sources or earmarked budgets. Such approaches have not generally been used as part of public financial management (PFM) in Botswana, and they are not generally considered to be part of PFM best practice¹⁹. Nevertheless, it could be considered. Options that have been used or considered elsewhere include a tax on airline tickets or on cell phone airtime – although the logic of taxing a specific and somewhat arbitrary category of producers or consumers to finance an unrelated activity needs to be well explained for it to be socially acceptable. Other options that could be considered include utilising the proceeds of the existing alcohol levy (which would raise an estimated P350 million in 2019/20) or an additional one percent on VAT (estimated P750 million). Besides the principle of earmarking, doing so in practice would have to address the issues of whether HIV-related programmes deserve higher priority than other pressing needs (such as other healthcare spending, basic education, social protection etc.). Earmarking may also be counterproductive, if it is compensated by a reduction in allocations from general revenues.

PEPFAR, through the Health Financing and Governance (HFG) project, has been assisting MOHW in developing a Health Financing Strategy. This is designed to both improve efficiencies in the health system, and to analyse potential alternative sources of funding. This has led to work to define packages of essential services, a framework for setting tariffs for health services, and

¹⁷ The two figures are not entirely comparable, however. The Investment Case projections include all costs related to treating HIV and AIDS, including general health system costs such as salaries, drug costs (other than ART) etc. In budgeting terms, these costs are not separately identified as part of HIV and AIDS spending.

¹⁸ However, this may be partially offset by anticipated reductions in financial requirements due to the impact of Treat-All; the 2016 Investment Case estimated that total costs would fall by almost 20 percent over the ten years from 2017 to 2027 as the benefits of reduced infections and hence treatment costs come through.

¹⁹ It has been used in some cases where the usage is linked to the revenue source, e.g. a fuel levy paid into the Road Fund for road maintenance, but in almost all cases revenues are paid into the Consolidated Fund.

budgeting processes for districts and health facilities. While not specifically related to HIV and AIDS, the HFG work is closely related to financing challenges.

Takeaways

- The Government of Botswana contributes around 60 percent of the identified costs of HIV and AIDS programmes (the proportion would be higher if indirect costs were included).
- Donor support plays an important role, and HIV and AIDS programmes are the only significant beneficiaries of donor funds in Botswana.
- The Government of Botswana share of HIV and AIDS spending amounts to around 2 percent of total government spending over the past five years
- Botswana has been unable to spend the full allocations from donors due to inefficiencies in implementation
- The anticipated decline in donor funding in the medium term will require increased allocations from government to maintain HIV and AIDS programmes
- A better information base is required to identify likely resource gaps in the coming years

6. Policy Issues

The future sustainability of HIV and AIDS programmes raises a number of policy issues that need to be addressed.

ART for non-citizens: ART is only provided to citizens through the public health service, and non-citizens are excluded. As a result, treatment rates for HIV-positive non-citizens are much lower than for citizens. This is a major weakness in the national response and will make the achievement of treatment cascade targets as well as epidemic control much more difficult.

Improving programme efficiency: There remain organisational inefficiencies in the administration of AIDS and HIV programmes, which affects both the effectiveness of spending as well as access to donor funds. As elsewhere in government, identifying the sources of inefficiencies and addressing them so as to get improved value for money is a high priority.

Updated statistics and resource requirements: there is high reliance on modelled estimates for information on HIV and AIDS, and hence for assessment of whether various targets are being achieved. The reliability of these estimates is crucial – as it affects policy (determining what priorities should be); resource needs (e.g. projections of treatment costs), resource allocation, and access to resources (donor funds are to some extent dependent on whether targets are being met). At present there are no up-to-date projections of resource needs for Botswana. The most recent BAIS results are now very out of date, and there are major inconsistencies between the HIV and AIDS numbers reported in the NSF-III and by UNAIDS. They need to be regularly updated.

Impact of reduced donor funding and a more general fiscal squeeze: the likely reduction of donor funding in coming years and a more general fiscal squeeze in the face of declining government revenues will pose challenges in maintaining sufficient public funding of HIV and AIDS programmes. Arguments for maintaining and increasing domestic funding in the face of competing demands will need to be supported by evidence and impact analysis – hence the importance of high-quality data noted above. In due course the beneficial impact of Treat-All will be realised with lower rates of new infections, and hence reduced treatment costs. Nevertheless, additional budgetary allocations of around P0.5 billion a year will be needed in the medium term to ensure that the full range of HIV and AIDS programmes are maintained.