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BOTSWANA PRIVATE HEALTH SECTOR ASSESSMENT

April 2014

This document was produced for review by the United States Agency for International Development. It was prepared by Sean Callahan, Tanvi Pandit-Rajani, Ilana Ron Levey, and Thierry van Bastelaer for the Strengthening Health Outcomes through the Private Sector (SHOPS) project.

SHOPS
Strengthening Health Outcomes *through* the Private Sector

Recommended Citation:
Callahan, Sean, Tanvi Pandit-Rajani, Ilana Ron Levey, and Thierry van Bastelaer. 2014. *Botswana Private Health Sector Assessment.* Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

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Cooperative Agreement: GPO-A-00-09-00007-00

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ACRONYMS

ACHAP	African Comprehensive HIV/AIDS Partnerships
AFA	Associated Fund Administrators
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BBCA	Botswana Business Coalition on AIDS
BHPC	Botswana Health Professions Council
BOCAIP	Botswana Christian AIDS Intervention Programme
BOCONGO	Botswana Council of Non-Governmental Organizations
BORNUS	Botswana Retired Nurses Society
BPOMAS	Botswana Public Officers' Medical Aid Scheme
CMS	Central Medical Stores
CTA	Central Transport Authority
GDP	Gross Domestic Product
GOB	Government of Botswana
GP	General Practitioner
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Syndrome
LIM	Low-Income Medical Aid Scheme
MAF	Medical Aid Fund
MAS	Medical Aid Scheme/s
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NBFIRA	Non-Bank Financial Institution Regulatory Authority
NGO	Nongovernmental Organization
NHA	National Health Account
ODA	Official Development Assistance
OOP	Out-of-pocket
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief

PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnership
PSA	Private Health Sector Assessment
SCMS	Supply Chain Management System
SHOPS	Strengthening Health Outcomes through the Private Sector
SMC	Safe Male Circumcision
USAID	United States Agency for International Development
USG	United States Government
VAT	Value-added Tax
VCT	Voluntary Counseling and Testing

ACKNOWLEDGMENTS

The authors have chosen to list their names alphabetically in the citation in acknowledgement of their equal division of labor in writing this report. Ilana Ron Levey served as the Team Lead for this assessment.

The authors thank Duncan Thela for his exceptional collaboration, inputs, and intellectual contributions over the course of this assessment. This report is a much stronger product due to his involvement. We also thank Maipelo Madibela for her helpful and conscientious logistical assistance.

The authors acknowledge Joan LaRosa, Marlene Nkete, and David Brown from USAID/Botswana; Kanchan Reed, Botswana's PEPFAR Coordinator; as well as Shyami de Silva and Michelle Wu Yoon of USAID/Washington, for their guidance and support throughout the entire assessment process. We are appreciative of Tom Brown from the SCMS project for his thorough review of the supply chain sections. We are grateful to the United States Ambassador to Botswana, Michelle Gavin, for her interest in the findings of this assessment and their implications for PEPFAR support in Botswana. In addition, we thank Caroline Quijada for her outstanding critical review of this report and other outputs along the way, as well as to Jennifer Mino-Mirowitz for support in formatting and editing this document. We appreciate the efforts of Sara Sulzbach and Kylie Ingerson in leading early discussions about the scope of work for this assessment in 2012 and for drafting the original scope of work.

Finally, we thank the more than 80 respondents who so generously shared their thoughts and experiences about the private health sector in Botswana. We are appreciative of the warm response from the Ministry of Health, the National AIDS Coordinating Agency, and the private medical aid industry, as well as private practitioners. While we hope we accurately reflected their perceptions and suggestions, we take full responsibility for the content of this report.

EXECUTIVE SUMMARY

Long touted as a development success story, the Republic of Botswana faces regionally unique circumstances as it continues to develop and sustain its national HIV response. Located in southern Africa, this country of 2 million has experienced decades of economic growth thanks to a long history of stability, good governance, and sound fiscal management of its natural resource wealth, resulting in a per capita gross domestic product of US$16,300 and maternal and child health statistics that outperform the regional average. In addition to a recent rise in noncommunicable diseases, Botswana's main health challenge is its persistently high HIV prevalence. Between 1985 and 2001, HIV prevalence in the country rose to a peak of 27 percent of the adult population. Prevalence has since declined to 23.4 percent (as of 2011), or 300,000 people living with HIV (PLHIV). The government of Botswana (GOB) is currently implementing its Vision 2016 Strategic Plan, which emphasizes both treatment and prevention, with the goal of zero new HIV infections by 2016. Government investments in treatment – supported by partnerships with the U.S. government and with the African Comprehensive AIDS Partnerships (ACHAP), a public-private partnership with funding from Merck Pharmaceutical Company (MSD) and the Bill & Melinda Gates Foundation – have already helped 95 percent of eligible PLHIV receive antiretroviral therapy and 94 percent of pregnant women receive care for prevention of mother-to-child transmission.

These impressive gains in HIV treatment and prevention outcomes are threatened by a number of converging factors. Although the GOB has used its natural resource wealth to fund the majority of its HIV and AIDS programs, the country still receives significant support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and ACHAP funded by Merck Pharmaceuticals and the Gates Foundation. Overall, external resources accounted for 8 percent of total health expenditures in 2010 and 52 percent of HIV and AIDS expenditures in 2009. Over the past 10 years, PEPFAR has invested hundreds of millions of dollars into Botswana's health system. ACHAP has provided additional financial resources, as well as access to free antiretroviral drugs. Going forward, PEPFAR has announced that it will begin reducing its funding support and moving toward a purely technical assistance model to Botswana as part of its transition strategy. The current arrangement for supplying ARVs through ACHAP is set to expire at the end of 2014 and additional funding for ACHAP through the Gates Foundation and Merck Company Foundation is not anticipated.

With the possibility of these two key supporters decreasing their support, the GOB and United States Agency for International Development (USAID) have begun investigating alternative strategies to continue financing and sustaining Botswana's HIV and AIDS programs. To this end, USAID engaged the Strengthening Health Outcomes through the Private Sector (SHOPS) project to conduct a private health sector assessment (PSA) in 2013 to examine Botswana's private health sector and develop recommendations for leveraging private health sector resources – including financing, personnel, and pharmaceutical commodities and supplies – in support of the country's HIV response. In preparation for the PSA, SHOPS conducted an extensive review of available published and gray literature pertinent to the objectives of the assessment. The SHOPS team conducted over 80 stakeholder interviews in May 2013, which helped reveal the prevailing attitudes of public and private sector actors, donors, and implementers toward existing constraints and challenges in further leveraging Botswana's private health sector.

The PSA report lays the groundwork for better leveraging the private sector. First, the size, composition, and prospects for growth of private practice and the private commercial supply chain in Botswana are outlined, while detailing the policy environment for the private health sector. The PSA report discusses opportunities and constraints for better leveraging a substantial commercial health sector currently facing significant barriers to growth. Key opportunities include expanding the use of contracting arrangements between public facilities and the private sector actors, strengthening private sector representation to broker more effective service delivery partnerships, and shaping an effective enforcement system to ensure quality in the private health sector. Key constraints include the small population size, human resources for health shortages, and the reliance on a transitioning public sector supply chain for key public-private partnerships in HIV treatment.

In the section four of this report, SHOPS presents a roadmap for increasing private health financing sources through the existing medical aid schemes. These schemes represent a significant opportunity for increasing domestic financing of health services, but their growth is currently inhibited by a number of factors, mainly high levels of fragmentation in the medical aid industry, the cost of their products, and concerns over their regulation.

Section five focuses on innovative strategies to leverage the private sector in order to sustain key PEPFAR investments in safe male circumcision, HIV counseling and testing, and antiretroviral therapy. The report presents a number of opportunities to improve the revenue diversification potential of PEPFAR-funded nongovernmental organizations (NGOs) offering critical HIV prevention services, as well as strategies to increase the provision of safe male circumcision in the private sector through networking, reinforcement, and a more accurate medical aid scheme tariff.

Overall, tremendous opportunities exist in Botswana to leverage the private health sector to sustain the impressive achievements made in the prevention and treatment of HIV and AIDS. This assessment provides a plan to leverage these opportunities for donors, the Ministry of Health, and private sector actors while identifying some challenges that currently hinder the expansion of private health care in Botswana.

Key recommendations from the PSA are summarized in Table 1.

TABLE 1. KEY RECOMMENDATIONS

Recommendation Area	Recommendations
(1) Better leverage the private health sector	• Strengthen private sector representation with the Ministry of Health on critical issues of registration, licensure, enforcement, clinical dimensions and implications of contracting models, and access to new information on clinical best practices and advances in medicine • Support the transfer of enforcement responsibilities to the Botswana Health Professionals Council to improve oversight (and thus quality) of private practitioners • Consider partnership models, including mobile facilities, to strengthen primary health care • Build on Ministry of Health contracting experiences to maximize the use of existing private human resources through contracting-in of private providers
(2) Increase the role of private financiers in reducing the expected funding gap	• Support efforts to consolidate existing medical aid schemes that will result in fewer, larger, and stronger schemes that can take advantage of economies of scale and larger risk pools to lower costs • Develop lower cost insurance products and distribution channels that can target low-income workers and younger, healthier clients • Develop modified plan choices in the public and private sectors,

	including looking into the possibility of mandated coverage • Institute a supportive regulatory environment, including the resolution of supervisory concerns about collusion between and among the medical aid schemes and providers • Develop stronger risk sharing arrangements among the parties
(3) Sustain PEPFAR investments in NGO sustainability, safe male circumcision, HIV counseling and testing, and HIV treatment	• **NGO Sustainability:** Broker linkages – where appropriate – between NGOs and Botswana corporations to help diversify revenue and cross-subsidize operations for NGOs while providing necessary health services to Botswana's private sector • **Safe Male Circumcision:** Leverage the private health sector to deliver safe male circumcision by advocating for more medical aid schemes to cover it as an HIV preventative benefit; support actuarial analysis for a more accurate tariff; consider networking or other reinforcement mechanisms for private providers • **HIV Counseling and Testing:** Pursue appropriate options to increase private sector provision of HIV counseling and testing, whether through Ministry of Health contracting NGOs, training and utilizing private laboratories and pharmacies in counseling and testing, or conducting an independent actuarial analysis and advocating increased medical aid scheme coverage • **HIV Treatment:** Conduct cost analysis for outsourcing antiretroviral procurement to a third-party; assess the implication of revising the evaluation criteria for bids; conduct a cost analysis to understand the scalability and expansion of the existing public-private partnership model for delivering antiretroviral therapy

1. INTRODUCTION

1.1 BACKGROUND

Long touted as the quintessential development success story, the Republic of Botswana faces regionally unique circumstances as it continues to develop and sustain its national HIV response. Located in southern Africa, this country of 2 million has experienced decades of economic growth thanks to a long history of stability, good governance, and sound fiscal management. Since gaining independence from the United Kingdom in 1966, the country has transformed from one of the poorest countries in the world to a middle-income country with a per capita gross domestic product (GDP) of US$16,300 in 2011 (CIA, 2012). Much of this economic growth resulted from effective public management of the country's diamond wealth. In 1969, the De Beers Group established Debswana, a 50-50 joint venture partnership with the government of Botswana (GOB) to mine the country's diamonds, bringing an influx of resources that the GOB has reinvested in Botswana's citizens. Debswana currently accounts for approximately 30 percent of GDP and 50 percent of government revenue (De Beers, 2013). In an historic 2006 deal, De Beers agreed to shift its rough diamond trading operations from London to Gaborone for a 10-year period. This transfer, which began in 2012 and is expected to be completed in 2013, will bring an estimated US$6 billion in additional revenue to Botswana's economy (Curnow, 2012).

Driven in large part by the mining industry, which accounted for 31.1 percent of GDP in 2011, Botswana's economy has continued to expand in recent years. Despite a downturn in 2009 largely caused by the worldwide financial crisis, GDP grew by 7.0 percent in 2010 and 5.7 percent in 2011. Other key sectors of the economy include General Government; Trade, Hotels, and Restaurants; and Banks, Insurance, and Business Services at 16.4, 12.8, and 11.0 percent of GDP, respectively (Central Statistics Office, 2012) and, thus, the GOB remains a substantial employer. In 2010, 185,700 workers – or 49.7 percent of the formally employed workforce – were in the private sector. Another 46 percent of the formally employed served in central and local government and the remaining 4.3 percent worked at a parastatal (Statistics Botswana, 2011a).

Despite this sound macroeconomic base, the economy still faces some challenges. According to the most recent Core Welfare Indicator Survey, the unemployment rate in 2009/2010 stood at 17.8 percent for the general workforce and at 36.0 percent for 15–24 year olds. During this same period, 20.7 percent of the population lived in poverty, with 6.5 percent living on less than the equivalent of US$1 per day (Statistics Botswana, 2011b). Botswana's economic growth success story stands side by side with high levels of unemployment and endemic poverty.

Decades of sound fiscal management have helped the GOB translate economic growth into improved health outcomes. Between 1980 and 2011, childhood immunizations for diphtheria, pertussis, and tetanus increased from 71 percent to 96 percent coverage of children aged 12–23 months and the infant mortality rate dropped from 60 to 36 deaths per 1,000 live births. Between 2000 and 2010, the maternal mortality ratio declined from 350 to 160 deaths per 100,000 live births and tuberculosis incidence rates dropped from 955 to 455 cases per 100,000 people (World Bank, 2013). As shown in Table 2, Botswana's health statistics generally outperform the average sub-Saharan country, especially in the areas of maternal and child health.

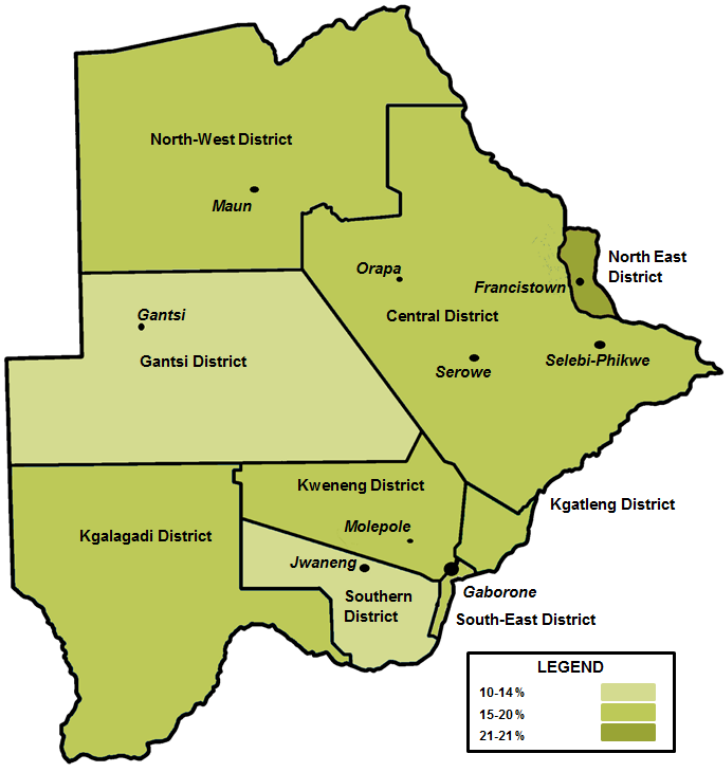
TABLE 2. COMPARISON OF HEALTH STATISTICS IN BOTSWANA

Indicator	Botswana	Year	Namibia	Year	South Africa	Year	Sub-Saharan Africa Avg	Year
Infant mortality rate (per 1,000 live births)	20	2011	30	2011	35	2011	69.3	2011
Maternal mortality ratio (per 100,000 births)	160	2010	200	2010	300	2010	500	2010
Prevalence of HIV, total (% of population, aged 15–49)	23.4%	2011	13.4%	2011	17.3%	2011	4.9%	2011
ART coverage among people with advanced HIV infection	95%	2011	95%	2011	66%	2011	56.9%	2011
Immunization, DPT (% of children ages 12–23 months)	96%	2011	82%	2011	72%	2011	70.7%	2011

Source: World Bank Development Indicator Database, Accessed May 5, 2013

As Table 2 also shows, Botswana's main health challenge is its high HIV prevalence. The country's first AIDS patient was reported in 1985. HIV prevalence continued to increase until it peaked at approximately 27 percent of the adult population (ages 15–49) in 2001. As of 2011, Botswana had the second highest HIV prevalence rate in the world at 23.4 percent of the adult population (World Bank, 2013), or 17.6 percent of the total population (Central Statistics Office and National AIDS Coordinating Agency, 2009). The HIV epidemic has not uniformly affected the country. As Figure 1 shows, prevalence is higher in the eastern portion of the country. According to the Botswana AIDS Impact Survey III, HIV prevalence among the total population is highest in the central and North-East districts, especially in Selebi-Phikwe (26.5 percent) and Sowa (25.4 percent). Prevalence is lowest in Gantsi district (Central Statistics Office and National AIDS Coordinating Agency, 2009).

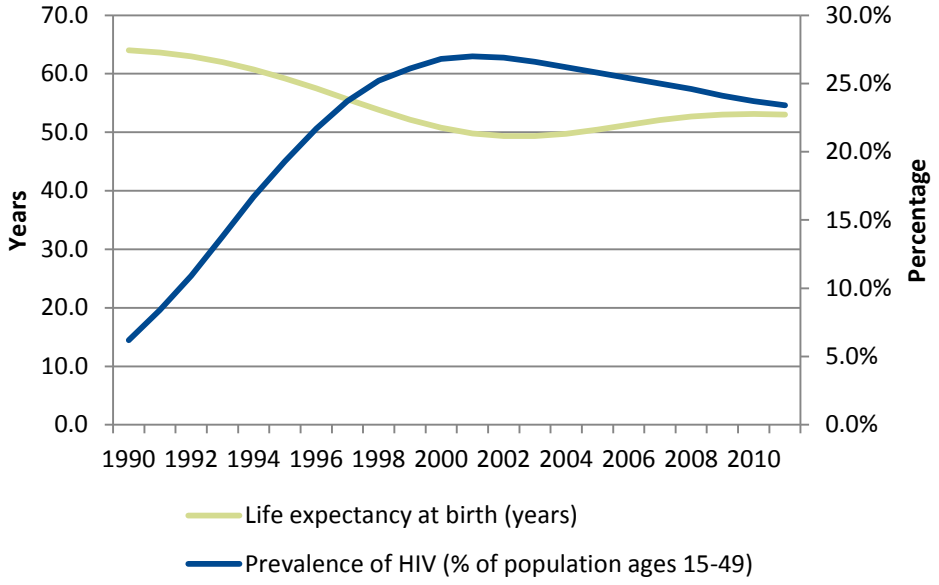
FIGURE 1. HIV PREVALENCE BY DISTRICT (PERCENT OF TOTAL POPULATION) (2008)



Source: Central Statistics Office and National AIDS Coordinating Agency, 2009

Corresponding with the spread of HIV, life expectancy dramatically declined, from 64 years in 1990 to 49 years in 2003 (see Figure 2). In recent years, as HIV prevalence declined, life expectancy slightly increased, and by 2011 it was at 53 years. The GOB's effective HIV response has largely driven this rebound. The government has repeatedly committed itself to ensuring that all citizens have access to affordable and quality health care services in its strategic documents. The National AIDS Coordinating Agency (NACA) has led the government's efforts to expand HIV prevention and treatment programs. Most recently, NACA has launched a national safe male circumcision (SMC) campaign to prevent HIV transmission and contribute toward the goal of zero new infections by 2016. GOB partnerships with the President's Emergency Plan for AIDS Relief (PEPFAR) and other donors have also helped to expand access to free or subsidized antiretroviral (ARV) drugs. In 2010, the country had approximately 300,000 people living with HIV (PLHIV). Of those eligible for antiretroviral therapy (ART), 95 percent, or 179,000, were on treatment (UNAIDS, 2013). Similarly, 94 percent of pregnant women receive care for prevention of mother-to-child transmission (PMTCT) of HIV (UNAIDS, 2013).

FIGURE 2. HIV PREVALENCE IN ADULTS, 15-49, AND LIFE EXPECTANCY IN BOTSWANA



Source: World Bank Development Indicators Database, Accessed May 5, 2013

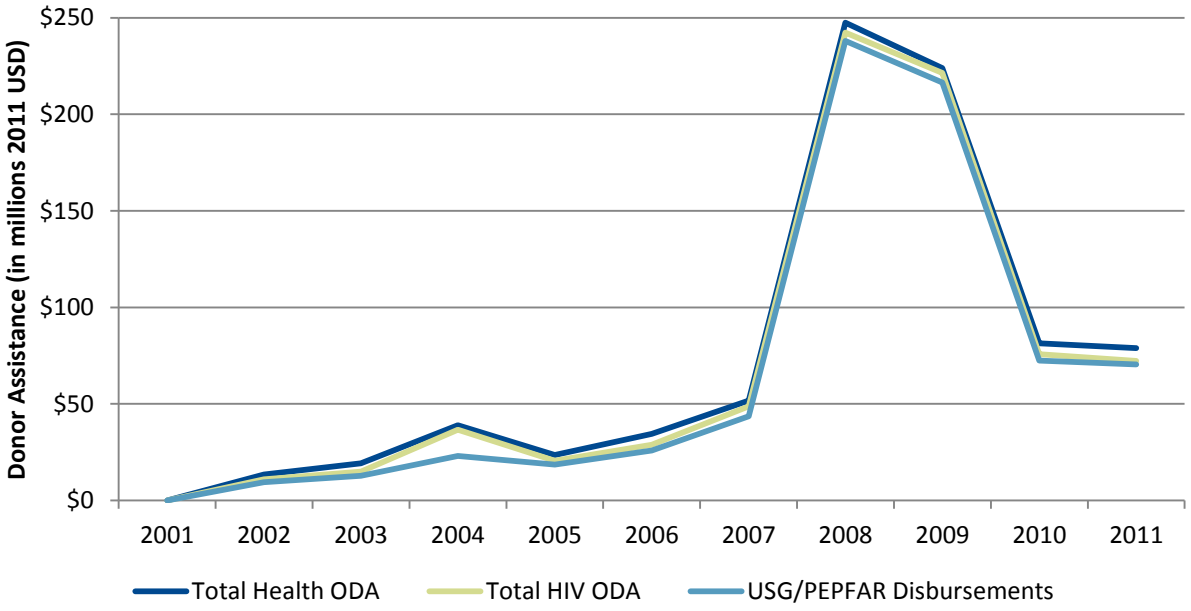
As Botswana successfully scaled up treatment and prevention interventions, the country's HIV response has transitioned. The disease no longer requires an emergency orientation to prevent HIV-related deaths. As more and more PLHIV survive on ART, the disease has evolved into a chronic, systemwide health issue that requires a sustained response. Similarly, as more and more people are living longer, chronic noncommunicable diseases like heart disease, cancer, and diabetes are increasingly becoming burdens on the health system, requiring additional investments in tertiary care facilities (HLSP, 2009), as well as strong primary health care and preventive services.

1.2 DONOR ASSISTANCE IN BOTSWANA

Donors – bilateral and multilateral agencies, as well as private foundations and companies – have played an integral role in the development of Botswana's HIV response. Throughout the early 2000s, official development assistance from bilateral and multilateral institutions to

Botswana for health and HIV mitigation programs increased dramatically. Prior to 2001, donor governments and multilateral institutions had not dispersed any health funding to Botswana despite previous commitments to do so. Between 2001 and 2008, these same donors began investing in Botswana's health system. According to the Organization for Economic Cooperation and Development, the amount that multilateral and bilateral donors disbursed for health programs increased from roughly zero in 2001 to US$250 million in 2008 (OECD, 2013). By 2011, however, this amount had declined back to approximately US$73 million. As Figure 3 shows, disbursements for HIV-specific health programs – largely provided by the United States government (USG) through PEPFAR – accounted for nearly all of this growth. The United States is the largest bilateral donor in Botswana, accounting for approximately 93 and 98 percent of official development assistance (ODA) for health and HIV programs, respectively, in 2011 (OECD, 2013). The bulk of this assistance goes toward technical assistance for treatment, care, and prevention (HLSP, 2009).

FIGURE 3. OFFICIAL DEVELOPMENT ASSISTANCE FOR HEALTH AND HIV IN BOTSWANA



Source: OECD, 2013; Health disbursements include "Health, Total" and "Population Pol./Progr. & Reproductive Health, Total"; HIV Disbursements include "STD control, including HIV/AIDS" and "Social Mitigation of HIV/AIDS"

**Note: Disbursement refers to the year in which the funding was actually transferred to the recipient country, not the year in which funding was allocated. Funds disbursed in 2008 may have been actually allocated in any of the preceding years. ODA estimates are for all aid categories, including but not limited to direct project costs, contributions to multilateral institutions, direct budget support, donor staff salaries and administrative costs.

Overall, the most important donors in terms of financial assistance are the USG, the World Bank, the Global Fund, United Nations agencies, and the African Comprehensive HIV/AIDS Partnerships (ACHAP). According to the most recent National Health Accounts (NHA) analysis, these donors accounted for approximately 8 percent of total health spending in Botswana in 2010 (Ministry of Health, 2012). Donors play a much larger role in financing the HIV and AIDS response, though. In 2009, it was estimated that external resources accounted for approximately 52 percent of resources (HSLP, 2009).

United States Government

As noted above, the USG is the largest bilateral donor in Botswana, having committed US$556.8 million since the launch of PEPFAR in 2004 (PEPFAR, 2013). This funding is channeled through multiple USG agencies, including USAID, the U.S. State Department, and

the Centers for Disease Control and Prevention. Today, the largest recipient of PEPFAR funds is the GOB (36 percent), followed by the Partnership for Supply Chain Management (10 percent) (PEPFAR, 2011). The GOB and other recipients spend 32 percent of total PEPFAR funding on prevention efforts (e.g., counseling and testing, SMC, sexual and biomedical prevention, and PMTCT), 23 percent on care and treatment (including ART), and 32 percent on health system technical assistance (e.g., management, staffing, and lab infrastructure) (PEPFAR, 2011). Given upcoming reductions in PEPFAR allocations for direct HIV prevention and care and treatment services in Botswana, this private health sector assessment (PSA) will focus heavily on private sector mechanisms for sustaining successful gains in HIV prevention and treatment.

World Bank

In 2008, the World Bank approved a five-year loan worth US$50 million to the GOB. The loan was intended to improve treatment coverage, efficiency, and sustainability of the country's HIV response (World Bank, 2008). The program channels 15 percent of the loan to the National AIDS Coordinating Agency, 40 percent to public sector ministries, and 45 percent to civil society organizations and private sector partners (HLSP, 2009).

ACHAP

Although they are not included in the estimates of ODA, private foundations and companies have also significantly contributed to the success of Botswana's HIV response. ACHAP a partnership between the GOB, the Gates Foundation, and the Merck Company Foundation, first formed in 2000. The partnership began with a five-year, $100 million program (later extended to nine years and $106 million) that focused on building infrastructure, training health workers, and providing other support to help strengthen the health system. In addition, Merck began donating two ARV drugs for the duration of the partnership. In 2010, ACHAP began implementing Phase II – a five-year, $60 million extension that would go toward supporting the implementation of Botswana's national strategic framework on HIV and AIDS. Program activities include prevention efforts and a drive to ensure the sustainability of the national HIV response (ACHAP, 2013). The current funding arrangement is set to expire in 2014.

European Union

The European Union is the newest major donor for Botswana's health sector. At the beginning of 2013, the European Union and the GOB announced a new contribution of over $15 million that would fund maternal and child health priorities with the goal of meeting the health-related Millennium Development Goals (Government of Botswana, 2013). Specifically, the GOB plans to use the European Union funding to improve and strengthen family and community-oriented health services in order to reduce maternal, infant, and child mortality rates (Government of Botswana, 2013).

1.3 CHANGING CONTEXT FOR PEPFAR IN BOTSWANA

Given the centrality of the USG in Botswana's ODA for health and HIV, the future trajectory for PEPFAR in Botswana is important and in flux. According to the Center for Strategic and International Studies, "*U.S. funding through PEPFAR is anticipated to decrease…to a plateau of $35 million by 2016, with an annual reduction in funding of about $10 million per year* (Stash et al., 2012)." These sharp reductions are largely in response to Botswana's high GDP, strong government commitment to financing HIV costs, and small population. Although it is clear that PEPFAR is significantly reducing the amount of funding for Botswana and is moving toward a purely technical assistance model to strengthen the Ministry of Health's (MOH's) capacity to effectively lead its HIV response (with PEPFAR offering little to no expenditures on service delivery or direct staff support, although PEPFAR does currently support staff secondments of

nearly 150 personnel for national HIV and AIDS agencies), other elements of this PEPFAR transition are less clear. PEPFAR is likely to continue support to Botswana beyond 2016, and may continue to prioritize investments in key prevention services, including SMC.

However, while the future direction and details of PEPFAR in Botswana cannot be definitively ascertained at this point, several key facts remain clear:

a. The amount of PEPFAR ODA to Botswana is reducing, and reducing rapidly.

b. The PEPFAR transition is not the only transition facing Botswana in the health sphere. New transitions, including the emergence of noncommunicable diseases, the sharp reduction of donor support to ACHAP, and changes in the nature of donor funding for supply chain management, will also affect the future of HIV services in Botswana.

c. Although the GOB has financed a high proportion of HIV services in the country, particularly compared to the rest of sub-Saharan Africa, PEPFAR reductions will contribute to a significant resource gap for HIV funding.

d. HIV prevention services, particularly those delivered by PEPFAR-funded nongovernmental organizations (NGOs), may be at particular risk as PEPFAR funding for non-technical assistance activities is reduced.

Given these realities, the development of strategies to inform the direction and shape of PEPFAR assistance for the near term are warranted. While there have been many PEPFAR, GOB, and other donor-led efforts to explore possibilities for improving the provision of public sector HIV services, as well as resource mobilization strategies to help alleviate the projected future funding gap, there has been little concerted effort to explore the potential role of Botswana's private health sector in providing and financing HIV and other essential health services given the changing nature of PEPFAR assistance in Botswana.

1.4 ASSESSMENT PURPOSE AND SCOPE

This PSA aims to document, synthesize, analyze, and present important information about Botswana's private health sector and ultimately to craft an operational and usable roadmap for stakeholders within Botswana to better understand, partner with, and leverage private sector resources in a time of transition. Given the key known facets of the PEPFAR transition in Botswana, particular attention will be paid to health financing, service delivery, the management of pharmaceuticals and medical supplies, and the policy environment for effective health sector public-private partnerships (PPP).

To achieve this goal, the PSA will do the following:

- Provide an overview of private health sector stakeholders and their respective roles
- Analyze prospects and challenges for private health sector growth in Botswana
- Describe private sector contributions and opportunities for growth in health financing
- Identify innovative mechanisms to sustain priority investments in HIV services through the private sector
- Provide recommendations on how best to operationalize PPPs in the health sector.

2. OVERVIEW OF REPORT

SHOPS and its predecessor project, Private Sector Partnerships-*One*, have conducted more than 25 PSAs over the past five years, including several in sub-Saharan Africa. As Figure 4 shows, a PSA typically consists of four steps: data collection, data synthesis and analysis, report preparation, and report finalization. All four steps emphasize collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations.

FIGURE 4. STEPS IN A PRIVATE HEALTH SECTOR ASSESSMENT

In addition, the PSA team coordinated closely with NACA from March–May 2013. NACA facilitates a Private Sector HIV and AIDS Partnership Forum that brings together private sector representatives, typically from workplaces, as well as donors with a private sector mandate. This technical working group is chaired by the Botswana Business Coalition on AIDS (BBCA) and seeks to organize and increase private sector contributions toward fighting HIV and AIDS. In 2013, NACA and BBCA sponsored a private sector-focused assessment to map and quantify the extent of workplace contributions toward HIV and AIDS in Botswana. The information gleaned from the NACA/BBCA assessment will inform the development of a public-private policy framework to help encourage a more active private sector role in combatting HIV and AIDS. During extensive discussions with NACA, the PSA team determined that it would not focus on workplace HIV programs (except with a lens toward prospects for NGO sustainability) in an effort to not duplicate efforts. Taken together, these two assessments should offer a full and robust picture of the private health sector in Botswana.

2.1 KEY TERMS

A few terms used in this report require definition. We define **private hospital** as "a [private] house where persons suffering from any sickness, injury, or infirmity are given medical or surgical treatment, or nursing care, and includes a maternity hospital or home, a convalescent home, a nursing home, or a rejuvenation centre" (Government of Botswana, 2001). The definition of private hospital in Botswana is more expansive than in some other African countries and does not specify the type of medical treatment offered. We use the term **contracting out** to refer to an arrangement whereby the GOB enters into a legal partnership with a private provider (or private medical aid administrator) for the delivery of goods or services outside of public facilities. **Contracting in** refers to a converse legal partnership whereby private entities deliver goods or services within public facilities. Although the term **PPP** carries a range of interpretations depending on donor or government, we use the standard PPP conception of a partnership between the public and private sector for the purpose of delivering a project or service that is bound by legal or contractual formality. Where relevant in the course of the PSA, we introduce opportunities as well for **private-private partnerships** that characterize service delivery models between two private (nonprofit or commercial) entities.

In addition, many seminal works (including Harding and Preker, 2003 and Harding, 2009) address the key ideological debates shaping private healthcare provision and resultant public-private dynamics. In approaching this PSA, we share these authors' perspective that a strong public-private mix improves healthcare, and that a focus on sustainable and effective solutions trumps absolutist views on public and private roles. In addition, we support PEPFAR's vision for "shared responsibility" and greater private sector involvement in the provision of HIV and AIDS services.

2.2 METHODOLOGY

In Botswana, the PSA team was composed of three international private sector experts from the SHOPS project and one senior health financing expert with significant experience in Botswana's medical aid industry.

Step One: Collect Data

To better understand the current political, economic, and social landscape in Botswana, the PSA team began with a background review of gray literature, published key policy documents, and previous studies on the private health sector and Botswana's HIV response. In addition, the PSA team reviewed the data from the most recent NHA report. This preliminary analysis and literature review provided an overview of the Botswana health system, the history of the government's HIV response, key policies related to private health sector provision of care, current government plans to work with the private health sector, existing health PPPs, and the current status of the private health sector. This preliminary analysis provided a comprehensive picture of emerging issues within the private health sector, and suggested key knowledge gaps to focus on during the in-country stakeholder interviews.

Following the literature review, the PSA team leader travelled to Botswana in April to refine the scope of work with USAID/Botswana, NACA, and the MOH (see Annex A for the proposed scope of work). The PSA team travelled to Botswana from May 6–17, 2013, to conduct key stakeholder interviews and collect additional gray literature. Using a key informant interview guide fined tuned by SHOPS through its previous private sector assessments, the assessment team met with a broad range of representatives from the public, private nonprofit, and private for-profit health sectors. The PSA team interviewed more than 80 individuals from approximately 45 organizations, including government officials, donors present in Botswana, USAID implementing partners, private medical aid schemes, faith-based organization and NGO

representatives, industry representatives, and private health care providers. While most of the stakeholder interviews took place in Gaborone, team members also interviewed private providers in Francistown and Maun. A list of all stakeholders interviewed by sector is included as Annex B. The assessment team worked with local counterparts to select key stakeholders based on a number of criteria, including their role in the Botswana health system, the degree to which they represented their respective fields, and the size and scope of their work.

Step Two: Analyze Data to Develop Findings and Actionable Recommendations

The analysis began while in-country. Through nightly debriefings, the PSA team shared information, vetted initial findings, and began to form actionable recommendations. At the end of the data collection trip, the PSA team held a larger consultative meeting with a stakeholder group that consisted of representatives from the MOH, NACA, USAID, and the private health sector to present a first-cut outline of findings, priorities, and recommendations. While drafting the report, the PSA team also sent questions back to local counterparts for additional information and clarification.

Step Three: Prepare the Report

Based on the initial data analysis and stakeholder interviews, individual team members prepared their respective modules. The assessment team leader compiled these sections into one consolidated draft, which was then shared with the entire PSA team and SHOPS senior management for comments on the content and structure of the report. The team then shared a second draft for verification and feedback with a wider technical audience, including members of the MOH, NACA, and USAID.

Step Four: Finalize the PSA Report

Following this distribution for comment, the assessment team produced a final draft that reflects the comments and concerns that local stakeholders raised.

2.3 OVERVIEW OF THE REPORT

The report is divided into six sections, covering in detail the key technical areas germane to better leveraging the private health sector in preparation for a confluence of transitions in Botswana. Following the introduction in Section 1, Section 2 presents the methodology used to conduct the PSA. Section 3 provides a landscape analysis of the size, composition, and prospects for growth of the private health sector in Botswana, while detailing the policy environment for private practice. Section 4 describes a roadmap for increasing private health financing sources, and Section 5 proposes a series of innovative ways to leverage the private sector in order to sustain key PEPFAR investments in SMC, HIV counseling and testing (HCT), and ART. Section 6 summarizes and concludes the PSA report. Throughout each section, we present operational recommendations and guidance on how to utilize the information presented in the PSA.

3. PRIVATE HEALTH SECTOR LANDSCAPE

This section presents a portrait of Botswana's private health sector as of mid-2013. The section describes the overall policy environment for the private health sector, the history of partnering with the private sector in Botswana, the size and composition of the private health sector, and a discussion of the key challenges and prospects influencing private health sector contributions. Finally, we end with a series of operational recommendations to better leverage the private health sector for quality service delivery in Botswana.

3.1 THE POLICY ENVIRONMENT FOR THE PRIVATE HEALTH SECTOR

Botswana has a **generally supportive policy environment that encourages leveraging the private health sector**. Several key documents guide the health sector and the national HIV response, including the National Health Policy (2011), Vision 2016, Integrated Health Service Plan, and the National Strategic Framework for HIV/AIDS. The directorate of planning, learning, and monitoring and evaluation is responsible for the development of innovative PPPs for service delivery, and their execution is the mandate of the health hub coordinator. Table 3 summarizes essential policies and legislation guiding health service delivery and identifies the most salient private sector statements from each document. These four key documents explicitly call for the development of PPPs for service delivery, which will be discussed in depth in this section.

TABLE 3. KEY POLICIES AND LEGISLATION

Policy	What Does it Do?	What Does it Say about the Private Sector?
National Health Policy (2011)	Updates the 1995 National Health Policy, with specific directions for each of the six World Health Organization health system building blocks	Calls for developing innovative public-private partnerships for service delivery, human resource planning, supply chain management, and planning and budgeting
Vision 2016	Identifies development goals for 2016, including universal access to quality health services and no new HIV infections	Calls for contracting out of services to private sector when warranted, leveraging private sector funding for HIV research and prevention, and building more effective public-private partnerships

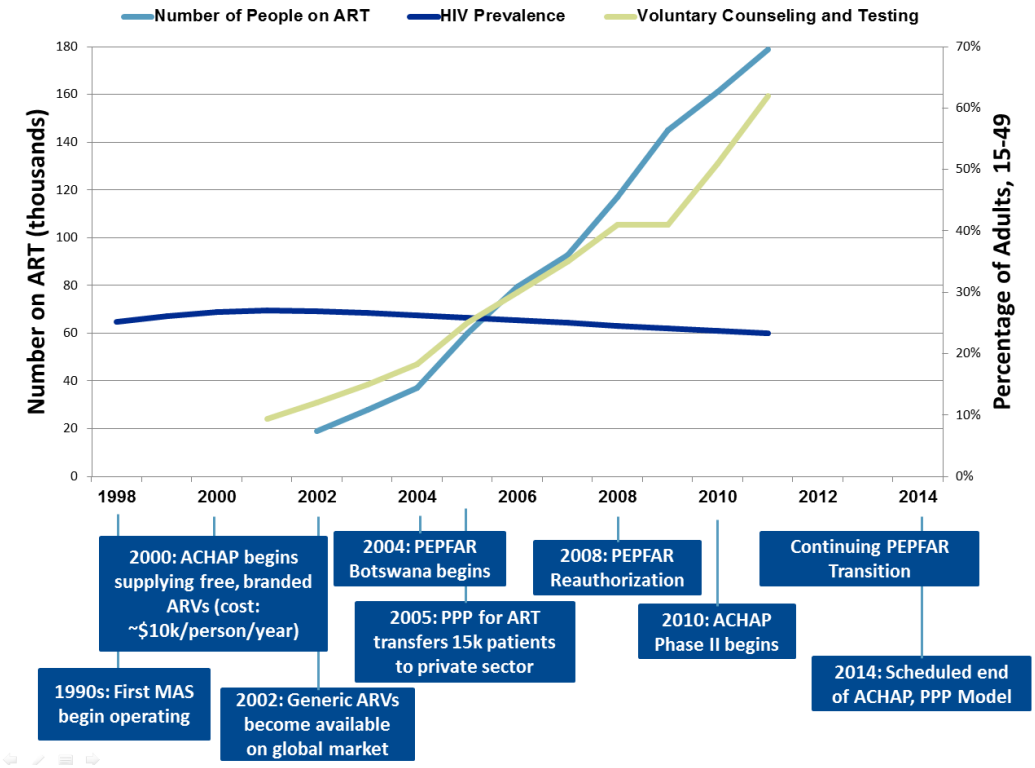
Integrated Health Service Plan: A Strategy for Changing the Health Sector for a Healthy Botswana 2010-2020 (2010)	Guides the implementation of Botswana's revised National Health Policy. Goals include: • Ensure universal coverage of essential health services, as well as efficient and effective delivery of health services • Ensure an adequate supply of highly skilled human resources for health • Ensure that sufficient funds exist to finance the health system, with particular consideration for the effects on at-risk groups	Calls for active involvement of the private sector and the development of public-private partnerships to achieve stated goals, including: • Leverage private providers to deliver essential health services • Increase quality of services in public, private, and nonprofit settings • Strengthen BBCA capacity to participate in HIV response • Include private sector in systemwide human resource planning • Explore increased support for health insurance
National Strategic Framework for HIV/AIDS 2010-2016	Outlines the following priorities for the national HIV response through 2016, with the goal of reducing prevalence and eliminating transmission of the disease: • Prevention • Strengthening of the health system • Strategic information management • Care and treatment	Calls for building and expanding public-private partnerships for service delivery

3.2 HISTORY OF PARTNERING WITH THE PRIVATE HEALTH SECTOR

As seen above, there is a strong legislative and policy basis for partnering with the private sector to expand service delivery. This mindset within the GOB is not new; Botswana has a **notable and unique history in partnering with the private sector** to expand access to essential HIV services. Botswana was the first country to initiate and scale up a public sector ART program and embrace the private sector as a critical partner to help finance and deliver HIV and related health services. Since 2005, select private providers have been trained by the MOH in ART delivery, and the first providers of ART in Botswana were from the private sector. Currently, private providers in Botswana offer the full range of HIV services, from prevention to treatment. However, both private and public health facilities focus heavily on HIV treatment, while NGOs play a leading role in the provision of HIV prevention services, including HCT and SMC. In addition, NGOs offer most of the palliative and vulnerable children care in the country.

The retrospective analysis presented below and summarized in Figure 5 provides a brief historical perspective on various initiatives that have shaped the role of the private sector not only in the HIV response, but in Botswana's overall health system.

FIGURE 5. EVOLUTION OF BOTSWANA'S HIV RESPONSE



Partnership with the Private Sector Provides Access to Lifesaving Medications

In the mid-1990s, lifesaving ARV medications became available in the global market but were cost prohibitive to most of the developing world. It is estimated that during this time, the per-person, per-year cost for first line treatment was more than $10,000, largely due to a lack of generic formulations (Global Fund, 2012). When Botswana was at the height of its HIV epidemic in 2000, the Merck Company Foundation, through its support to ACHAP, donated the latest ARV medications to treat HIV. This partnership not only facilitated access to ARVs, which would have otherwise been unaffordable to Botswana, it also helped establish one of the first national ART programs in Africa.

New Developments Facilitate Scale-up of ART and Create Capacity Constraints

Between 2002 and 2004, several important events shaped the future of HIV programming in Botswana. First, global advocacy efforts had succeeded in making generic ARVs available to the global market. As a result, the cost of treatment became more affordable to donors, governments, and patients worldwide. Second, due to low enrollment in the ART program, the government initiated a policy in 2004 to routinely provide HIV testing as part of all medical visits, where patients were given the choice to "opt out" (Weiser et al., 2006). The policy succeeded in increasing the uptake of HIV testing: between January 2004 and December 2005, enrollment in the national ART program climbed from 17,500 to nearly 56,000 patients – more than a three-fold increase in the number of patients receiving care and treatment (Weiser et al., 2006; World Health Organization, 2005). This rapid enrollment placed additional pressures on a public health system that was already facing chronic human resource shortages, resulting in limited capacity to absorb more patients. During this same time period, the arrival of PEPFAR brought an influx of resources into the country at a time of critical need. In order to take full advantage of this external aid, the MOH needed to develop more concrete strategies for partnering with the private sector to help meet the growing demand for ART services.

Private Sector Role Evolves through the HIV Scale-up Response

Strong political leadership, including a supportive policy and regulatory environment, encouraged private sector engagement in the response to HIV. For example, the Multi-Sector AIDS Plan (1997–2002) called for the establishment of the BBCA, which was mandated to coordinate the private sector response, including advocacy and support for workplace policies and programs. One of BBCA's key successes was the advocacy for Debswana to expand medical aid coverage from employees only to include families. As one of the largest employers in the country, Debswana's policy change set a precedent for other local businesses to extend medical aid coverage. Because medical aid schemes (MAS) had expanded their benefits packages to include HIV and AIDS services, insured PLHIV were able to obtain services through private providers.

By 2005, the government had implemented an innovative arrangement to contract out ART delivery to Associated Fund Administrators (AFA), a private medical aid administrator, allowing uninsured, public sector patients to access ART through private providers. This partnership helped relieve patient load within the public sector by transferring ART management and care of some PLHIV to AFA. Under this model, medications were provided free of charge by the GOB, but they were packaged, distributed, and accessed through private sector channels. This PPP, further discussed in Section 5, is still operational and currently manages 14,000 patients on ART. While the proportion of patients being supported through this scheme is relatively small, the partnership signified an evolution with regard to how PPPs were defined in Botswana. Until this point, the nature of many PPPs had largely focused on coordination and corporate contributions to support the GOB in the national HIV response. Various PPP experiences in health, combined with government emphasis on greater privatization, set the stage for more formalized relationships between both sectors in health service delivery, including the current MOH contracting out of non-core health functions at the hospital level, such as cleaning, laundry, and grounds maintenance.

This early adoption of partnering with the private sector for HIV service delivery distinguished Botswana from neighboring South Africa and Namibia. The distribution of physicians between the public and private sectors is also unique to Botswana, as both South Africa and Namibia have a far higher number of private physicians than public. As discussed below, the substantial size of Botswana's private sector, as well as its concentration in urban areas, influenced the GOB's decision to pursue partnership and contracting arrangements to expand health services.

3.3 DESCRIPTION OF THE PRIVATE HEALTH SECTOR

The GOB's commitment to ensuring free essential health services for all of its citizens has led to **public sector dominance of Botswana's health market**. Significant investments in the health infrastructure have enabled the vast majority of the population, including those living in rural areas, to be within an 8 kilometer reach of a health facility (Government of Botswana, 2011). However, chronic shortages of health care personnel, occasional stock-outs of medicines, and the impact of the HIV epidemic on the public health system have compromised the quality of care. Although the GOB is making considerable effort to address these issues, economic growth coupled with greater demand for high-quality services have given rise to the private sector as an important financier and provider of health care, particularly for HIV and AIDS.

3.3.1 SIZE AND DISTRIBUTION OF THE PRIVATE HEALTH SECTOR

Botswana's private health sector is highly concentrated in urban areas. The private-for-profit health sector comprises health clinics, hospitals, pharmacies, laboratories, and medical wholesalers/distributors, which, with the exception of three hospitals that serve mining areas, are mostly concentrated in urban centers where populations are able to pay for their services

and products. The country also has an advanced private laboratory infrastructure, most notably in the national laboratory company, Diagnofirm (see Box 1 for more information on Diagnofirm). Table 4 shows the breakdown of public and private health facilities in Botswana, by type.

Box 1. Leveraging Private Labs for the HIV Response: Diagnofirm Medical Laboratories

Diagnofirm is the largest Botswana-owned private laboratory company in the country. Since the early 1990s, the company has offered a variety of laboratory services offering the latest advanced technologies available. Its ability to provide high-quality, state-of-the-art services has made Diagnofirm a vital partner to both the private and public sectors throughout Botswana's national response to HIV.

As of 2013, its 60 staff members operated four laboratories and 22 "bleeding centers" around Botswana that serve approximately 12,000 patients annually. The vast majority of these patients are covered through one of the major MAS: BPOMAS, BOMaid, and PULA. Approximately 10 percent of its clients pay out of pocket.

Several private hospitals – including those owned by Debswana and BCL Mines – contract with Diagnofirm to provide medical laboratory services. Diagnofirm is well equipped to provide pre- and post-test counseling in-house for MAS patients. The public sector also contracts Diagnofirm to conduct viral load and CD4 testing through the MAS as part of a PPP. These tests can take up to three months in a public lab due to staffing shortages, but Diagnofirm can conduct the same tests within four hours. Although Diagnofirm does not profit from this PPP (the tests cost $34.68 and the GOB pays $39.18 through BOMaid), social responsibility is part of the company's core values and their commitment to help mitigate the impact of HIV throughout the country. Through these well-functioning partnerships with both public and private facilities, Diagnofirm is able to provide efficient, state-of-the-art laboratory and diagnostic services to help further strengthen Botswana's efforts to combat HIV and AIDS.

TABLE 4. DISTRIBUTION OF HEALTH FACILITIES BY TYPE

Facility Type	Public	Private
Hospitals	35	8
Public clinics	286	--
Private surgeries	--	354
Health posts	343	--
Pharmacies	--	106
Total Number of Facilities	664	468

Source: Public sector numbers from Central Statistics Office's *Health Statistics Report 2009;* Private sector numbers are from AFA registry, as of June 10, 2013.

Note: Private hospitals include company hospitals and faith-based hospitals; private surgeries include GP-led practices, medical specialist practices, family nurse practitioner-led practices, company clinics, and day care surgical clinics.

Overall, we see that there is a roughly equal distribution of general practitioners (GPs) between the public and private sectors and a significantly larger number of hospitals in the public sector. Stand-alone pharmacies are present only in the private sector and comprise a sizeable percentage of the total private health sector infrastructure. Stand-alone private doctors' surgeries are by far the most frequent type of private health facility and remain an integral source of private clinical assets.

The Botswana Health Professions Council (BHPC) registers all health workers in the country, including both public and private. Health workers are required to work in the public sector for three years prior to being allowed to practice in the private sector. Therefore, virtually all private providers in Botswana have public sector experience. Although the BHPC records suggest that there are approximately 6,000 health workers in the country, the Registrar acknowledged significant inaccuracies in the BHPC's record keeping and believes that 4,500 health workers is likely a more accurate number. BHPC is in the midst of reconfiguring and updating its data management system; incomplete data for private sector human resources is a result of unavailable data from the BHPC as of May 2013. The degree of missing data concerning the number of private sector health workers is high and indicates weak data management systems at the BHPC. In addition, Botswana appears to be unique amongst the many countries where

SHOPS has conducted a PSA in that the number of private providers is likely over-reported (according to the BHPC estimates), as opposed to the more typical under-reporting. This over-reporting is likely associated with insufficient longitudinal data management systems for tracking movement of private providers, both out of the country and into new roles within the country. Table 5 shows the estimated breakdown of key cadres of health workers between the public and private sectors.

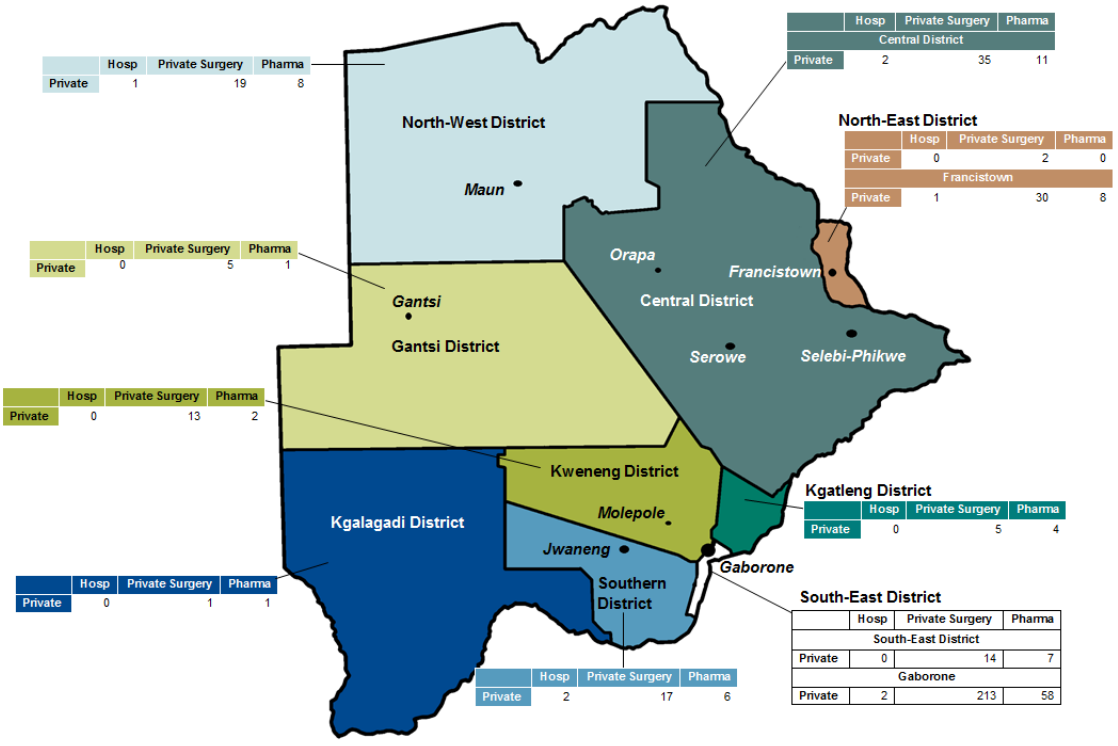
TABLE 5. HUMAN RESOURCES FOR HEALTH IN THE PUBLIC AND PRIVATE SECTORS

Cadre	Public Sector (2009)	Private Sector
Doctor (GPs and specialists)	819	
GPs	*683*	*650*
Nurses	5,816	
Laboratory technician/assistant	373	
Pharmacist/pharmacy technician	365	Est. 584

Source: Public numbers from Central Statistics Office' *Health Statistics Annual Report, 2009;* Private numbers from estimates by the Botswana Health Professions Council

Botswana's favorable economic, political, and health environment has helped attract a much needed cadre of health providers into the country, with foreign-born doctors accounting for 90 percent of all physicians (Campbell et al., 2012). However, given the size and distribution of the population, higher level health professionals, particularly physicians, are located in urban areas where 60 percent of the population resides. Figure 6 shows the distribution of private facilities in Botswana by district, and helps to highlight the overwhelming concentration of private practices in the urban centers of Gaborone and Francistown.

FIGURE 6. DISTRIBUTION OF PRIVATE FACILITIES BY DISTRICT

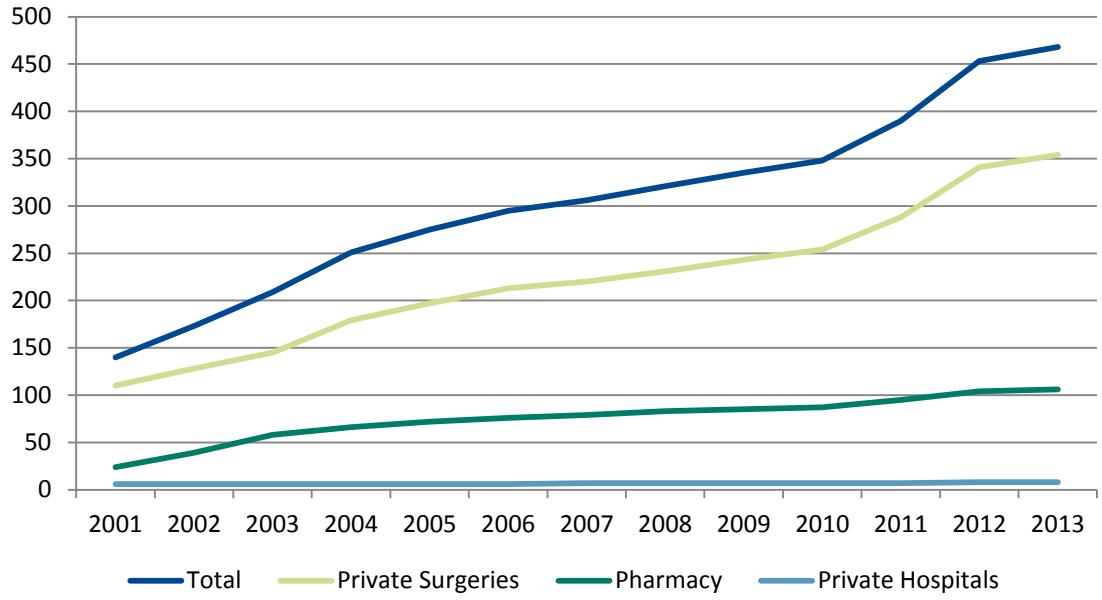


Source: BPOMAS and PULA registry, as of 10 June 2013

Ease of private provider registration and licensing have enabled physicians to set up individual practices or to join group practices. Until recently, registration and licensing requirements did not take into account the geographic spread of existing providers. This has led to a higher concentration of physicians in a few pockets of the country. Since private GPs are almost equal in number to public sector GPs, the health market in Gaborone is experiencing an oversaturation of private physicians. Interviews with private doctors revealed that they had a much lower patient volume today than 15 years ago, and steep competition and resulting declining patient load are forcing some providers, particularly in Gaborone, to close down their practices.

In addition, we were able to estimate trends in private sector growth over the last 10 years. Figure 7 shows a steady growth in the number of private surgeries and pharmacies over the last 12 years and suggests that the phenomenon of oversaturation has likely been exacerbated in the last three years. Interestingly, the number of private hospitals has largely remained flat-lined, likely due to significantly higher capital needs for opening a hospital. Although interviews suggested limited growth for private hospitals in Gaborone, some potential market gaps exist in Maun to serve local residents and safari tourists from Botswana, Namibia, Zambia, and Zimbabwe.

FIGURE 7. GROWTH IN PRIVATE HEALTH SECTOR, 2001–2013



Source: AFA Registry, as of June 10, 2013

3.3.2 REPRESENTATION AND ENFORCEMENT OF THE PRIVATE HEALTH SECTOR

Botswana's large number of private GPs is highly fragmented. There is only one private provider association in the country, the Medical Practitioners Association, and, historically, the main focus of this association has been negotiations with medical aid administrations on tariff rates (see Section 4 for a discussion about recent changes to the ability of private providers to negotiate directly with the medical aid industry). Discussions during the PSA revealed a weak association that is largely Gaborone focused, lacking adequate staffing levels, and without the ability to provide a platform for the discussion of the service provision, clinical, licensing, and enforcement issues facing private providers.

Currently, while the BHPC registers private providers in Botswana, the MOH is responsible for all licensure of private practices and enforcement of clinical standards for all private facilities. The MOH, under the purview of the director of health services, licenses private providers and examines the structure, equipment, and staffing levels of private facilities. In addition, medical aid administrators and some schemes separately inspect registered private facilities in order to ensure the quality of covered private services. In essence, a dual inspection and enforcement system exists between the MOH and the medical aid industry, and, as such, adds costs to both entities.

The MOH has an approachable and non-punitive enforcement system compared to many other African countries. Private facilities are rarely closed (e.g., no private hospitals have been forced to shut) and inspection occurs annually. If infractions are observed, the MOH creates an action plan to specify how the facility must respond in order to meet clinical best practices, and, ideally, a second enforcement visit occurs within 2-3 months. In practice, the inspectorate at the MOH is understaffed and not all annual enforcement and post-action plan visits occur as planned. Interestingly, interviewed private providers speak of a desire for greater enforcement and believe that "*enforcement improves quality. Building quality means the people will come* [to private facilities]." Given the weak ability of the Medical Practitioners Association to provide up-to-date information to private providers on clinical guidelines and new advances in medicine, an effective enforcement system to promote quality is particularly important.

In the next year, the MOH is looking to transfer licensure and enforcement responsibilities to the BHPC. The BHPC has exhibited generally positive attitudes toward private providers through an accommodating registration system and the development of a pilot Continuing Professional Development program for both public and private providers that contains private sector friendly modalities (e.g., weekend courses and virtual education). However, significant capacity gaps and questions remain around BHPC staff training, the number of inspectors, and data management abilities. Unless addressed, these gaps threaten the ability of the BHPC to effectively enforce quality in the private sector and will diminish prospects for the advent of a singular, unified enforcement system that the medical aid industry can trust. Only with that trust and a proven track record of effective enforcement will the medical aid industry consider reducing or dropping its own inspection visits.

3.4 CURRENT STATE OF PRIVATE PRACTICE

The private health sector has evolved over the last 20 years and currently serves as an important source for general and specialized health care for the rising and upper middle class. However, **many of the factors that facilitated its growth are now being threatened** in the face of increased public sector investments, urban saturation, and limited expansion in the number of new MAS subscribers. As the GOB embarks on initiatives to sustain its achievements in health and HIV, it must also consider the role of the private sector in serving population segments that are willing and able to pay for health services. Accordingly, this section describes Botswana's current private health sector through the lens of the HIV response. Given that demographic and health surveys, or similar analyses capturing health utilization patterns, have not been conducted recently in Botswana, a detailed market analysis quantifying the demand and growth of the private health market share is beyond the scope of this assessment. However, the authors have drawn upon existing literature, key informant interviews, and private sector registries to assess the influence of the HIV epidemic on private sector growth and identify options to sustain the private sector's role in the delivery of health care.

3.4.1 THE CURRENT MARKET FOR PRIVATE HEALTH SERVICES

Botswana's economic gains have facilitated greater demand for and affordability of private health services and products among certain segments of the population, creating a small market niche for private providers. This section aims to quantify the current market of the private health sector, including potential factors that facilitate as well as limit the opportunities for its growth. Special attention is also given to the private sector supply chain, as safe, affordable, and consistently available health products are vital to the success of Botswana's health program. Below are key attributes of Botswana's private health market as of mid-2013.

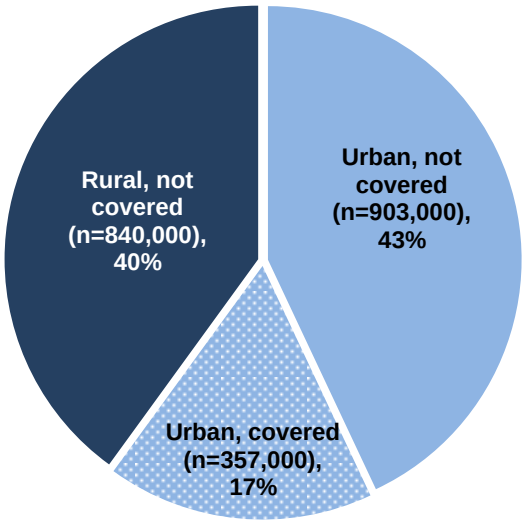
Private Health Spending Is on the Rise, but Is Limited to a Small Market

Private spending on health has been steadily increasing in Botswana. Household spending on health, combined with that provided by employers, constitutes approximately 25 percent of total health expenditures (MOH, 2012). Between 2007 and 2010, household contribution, as a share of all health spending, rose from 13 percent to 18.5 percent (MOH, 2012). Further research needs to be conducted to determine if this trend is simply the result of increased prices in the private sector, but another possible explanation is that the market segment that is willing and able to pay for health care is increasing its demand for private health services – an important consideration for the GOB as it confronts a potential funding gap in health (see Section 4 for a detailed discussion of private sector options to address the funding gap).

Several factors have likely influenced increased spending on private health care. Higher incomes due to strong economic growth in Botswana are enabling more individuals to pay for services either through MAS or direct out-of-pocket (OOP) payments. The private sector presents an alternative choice for patients who are concerned with HIV-related stigma or perceive the public sector to offer lower quality of care. And lastly, private providers may be able to more readily provide advanced treatment options with state-of-the-art facilities and equipment, otherwise unavailable in some public facilities.

The private health market is confined to the small proportion of the individuals who are either covered by medical aid or willing to pay OOP for services. Figure 8 shows that an estimated 357,000 individuals (17 percent of the total population) are currently covered through an MAS and mostly reside in urban areas.

FIGURE 8. URBAN-RURAL MAS COVERAGE



The Private Sector is a Critical Component to the Overall Supply Chain System

The HIV epidemic has brought supply chain issues to the forefront of program planning due to the complexities of ART management and the range of commodities required for comprehensive care. From the time ARVs became available to Botswana, the MOH has been an active steward in implementing policies, building local capacity, and leveraging the private sector to help strengthen its supply chain system. Both the public and commercial supply chains provide a broad range of medicines and supplies through their own respective procurement and delivery systems. A third, "hybrid" model involves a PPP that extends ART services to uninsured HIV patients through private sector channels.

The main actors in Botswana's private sector supply chain include manufacturers, distributors and wholesalers, providers, patients, and to some extent the medical aid industry, which sets reimbursement rates on medicines. Because local manufacturing capacity is very limited, wholesalers purchase products mostly from registered, South Africa-based international suppliers and manufacturers. Unlike many countries in sub-Saharan Africa, Botswana has implemented a policy that exempts prescription medications from the value-added tax (VAT) typically placed on imported goods. This policy supports the importation of pharmaceuticals and other medical supplies, and helps reduce the cost of products down the supply chain, ultimately benefiting the end user. Once health products are purchased through the international market, they are distributed by wholesalers to pharmacies, dispensing doctors, or other retailers. Occasionally, when shortages or stock-outs of medicines or other supplies are experienced within the public sector, local private wholesalers will sell products ad hoc to the Central Medical Stores (CMS), the MOH unit responsible for procurement, distribution, and management of public sector health commodities.

MAS set policies and regulations affecting the pricing of mark-ups down the private sector supply chain. Because of reimbursement caps enforced by the MAS, wholesalers' mark-ups on ARVs cannot exceed 5 percent, and are limited to 10 percent for all other medications. The maximum allowable mark-up from provider/retailer to the patient is 10 percent for ARVs; however, in some instances, the mark-up can exceed 50 percent for non-branded generic medications. Healthy competition appears to exist among private wholesalers, creating incentive to deliver high-quality services and products. Interviews with pharmacy chains and individual retailers indicated strong satisfaction with the range of available wholesalers, product prices, and timely delivery of service.

Throughout the scale-up of HIV treatment, donors and the MOH have heavily invested in various aspects of the public, commercial, and PPP model supply systems to ensure uninterrupted access to ARVs. However, the public sector supply chain that serves the vast majority of Botswana's ART patients is at risk. The following upcoming transitions will converge over the next year and will ultimately expose a successful ART program to public sector supply chain inefficiencies:

- PEPFAR support to CMS in procurement and logistics management shifting to greater country ownership (underway)
- MOH to contract out warehousing and distribution of medical products (imminent)
- MOH tender with BOMaid for PPP ART model expected to end (early 2014)
- Merck ARV donations through ACHAP expected to end (late 2014)

Overall, understanding how these changes will affect the public sector supply chain is crucial to understanding future prospects for the ARV PPP model and the growth of similar mechanisms.

PEPFAR Technical Assistance to CMS in Procurement and Logistics Management Is Phasing Down

The CMS, responsible for all procurement and logistics management functions, is the most critical actor in Botswana's public sector supply chain. To help build its capacity and improve supply chain performance, in 2007, PEPFAR initiated a technical support program through the Supply Chain Management System (SCMS) project. In late 2009, SCMS' support included management of all CMS operations to ensure timely procurement and delivery of vital and essential medicines, including ARVs. These investments have led to system improvements, resulting in:

- Full transition of CMS operations from SCMS to government staff;
- ISO 9001:2008 accreditation for quality management; and
- Reduction in stock-out and expiry of products.

Although SCMS has taken necessary measures to improve operational capacity and mitigate supply disruptions, stock-outs and shortages persist and system bottlenecks limit CMS' ability to be more effective. The following are some examples:

- **Funding disbursements create inefficiencies in procurement**. CMS receives funding from the MOH on an annual basis, but delays in disbursements disrupt the procurement cycle. Moreover, these one-year funding cycles affect planning and scheduling, creating additional delays in product ordering and delivery. For example, large volume orders are placed at the beginning of the year, but by midyear, CMS has drawn down on available funds. This forces CMS to put orders on "hold" or make smaller volume purchases until funds arrive. Lack of adequate funding also prevents CMS from buying products at volumes that would achieve better economies of scale.
- **Evaluation criteria favoring local suppliers may be more costly and inefficient**. Existing criteria require that bids submitted by citizen-owned businesses be evaluated at 10 percent less than actual cost. If the local business is selected, CMS pays full price. Currently, 50 percent of all purchases are made through local suppliers that survive on small volume procurements (CMS procurements are relatively small due to ordering cycles and population size). However, in many cases, it is more cost-effective to purchase from international suppliers. Recently, evaluation criteria favored purchasing condoms from the only local manufacturer in Botswana. The manufacturer failed to deliver products over several months, resulting in emergency condom shipments from donors.

3.4.2 CHALLENGES AFFECTING PRIVATE SECTOR GROWTH

Factors that once positively influenced the growth of the private health sector have recently shifted due to increased satisfaction with public sector facilities in saturated urban areas. With achievements in universal ART coverage, declining donor funding, and a high concentration of private providers in Gaborone, the changing nature of the health system in Botswana MOH may present new and unique challenges. While the MOH has heavily invested in tertiary care in urban areas and NGOs deliver essential HIV prevention services in rural and remote services, private providers largely offer both preventative and treatment services in urban areas. A market gap for low-cost primary health care in rural areas appears to exist.

In recent years, the MOH has increasingly taken more responsibility to address its own health system gaps, with specific emphasis on infrastructure development and human resources recruitment. Government financing alone will be insufficient to maintain these new investments

while simultaneously securing the necessary funds to fill the health budget gap for the long term. This section provides a brief description of current MOH initiatives that may inadvertently limit the potential of the private health sector in the foreseeable future.

The MOH is making substantial effort to expand access to high-quality specialty health services in the public sector, with heavy resource investment in health infrastructure. The MOH opened four state-of-the-art district hospitals in 2008; however, staffing of physician specialists within these new facilities has proven difficult due to the lack of available qualified health personnel in Botswana. In addition, a new, large university teaching hospital slated to open in Gaborone by 2015 will likely exacerbate the need for adequately trained health staff.

To better optimize the efficiency and use of its new tertiary health facilities, the MOH initiated a *Specialists Health Services Program* to contract-in private physician specialists into the four district hospitals. An Indian-based hospital group is responsible for placing 53 doctors at these facilities and will manage payment, accommodations, training, and/or other support as needed for a flat fee paid through a two-year MOH contract. As of April 2013, 40 Indian specialists have been recruited and assigned to various district hospitals.

Although the recruitment of these doctors may be necessary, private physicians currently residing in Botswana are underemployed. As described in Section 3.3.1, oversaturation of private doctors in Gaborone has led some physicians to close down their practices and left others unable to obtain licenses as new registration requirements now take into account the geographic distribution of providers. Opening private facilities in non-saturated, more rural markets would provide less competition for private practitioners but carries inherent risk due to limited population and market size.

Discussions with public and private providers also revealed that a widespread nursing shortage is preventing some facilities from operating at full capacity. For example, only 50 percent of beds at the private Bokomoso Hospital are opened, and this high vacancy is largely due to lack of qualified nursing staff. Yet, according to the Nursing and Midwifery Council of Botswana, 400–500 nurses are graduating across Botswana's eight nursing schools each year, but not all are able to find employment. In addition to these new graduates, nurses who were once employed through donor programs are now being "released" from externally supported employment. A current countrywide hiring freeze is preventing both new graduates as well as trained, experienced nurses from obtaining employment within the public health system, leading many of them to either retire or seek jobs outside of Botswana. Over the last decade, external aid has supported various positions across all levels of the health system, but as donor funds wane, there is no existing mechanism to employ these staff in public facilities.

3.5 RECOMMENDATIONS TO BETTER LEVERAGE THE PRIVATE HEALTH SECTOR

The above sections highlight the following:

- An amenable policy environment for private practice and PPPs for service delivery
- A sizeable private health sector with a significant number of health workers
- Challenges in the enforcement and representation of private providers
- A relatively stable market for private health services with little potential for robust growth
- An efficient and reliable private sector supply chain
- Numerous MOH initiatives designed to improve the public health of the country that may inadvertently impede private sector growth.

In this concluding section, we offer several operational recommendations to better leverage the private health sector in light of the discussion.

3.5.1 STRENGTHEN PRIVATE SECTOR REPRESENTATION

Ensuring strong and effective private sector representation is key to strengthening private sector "voice" and dialogue with the MOH on critical issues of registration, licensure, enforcement, the clinical dimensions and implications of contracting PPP models, and access to new information on clinical best practices and advances in medicine. The Medical Practitioners Association requires a broader mandate and vision to extend beyond medical aid negotiations, the ability to reach and adequately represent private providers outside of Gaborone, adequate staffing levels, and training in effectively negotiating with the MOH on issues of importance to the private sector. Currently, the medical aid industry is the primary point of contact with the MOH on discussions regarding new contracting options and the transfer of enforcement responsibilities from the MOH to the BHPC, and this configuration leaves individual private providers isolated, fragmented, and with little organized ability to give input into important items affecting their practice.

3.5.2 SUPPORT THE ABILITY OF THE BHPC TO EFFECTIVELY ENFORCE

PEPFAR already provides support to the BHPC, including in its development of a private sector-friendly Continuing Professional Development pilot program. Once private practice enforcement functions are fully transferred to the BHPC, extensive capacity-building will be necessary. Currently, the BHPC lacks a sufficient number of staff and future inspectors, and has weak data management systems to support accurate and efficient reporting on private sector quality. Because of high levels of private provider fragmentation and lack of access to new advances in medicine (see above Section 3.5.1), private providers in Botswana are particularly in need of a strong enforcement system that supportively guides private facilities in the steps needed to provide high-quality care. In addition, Section 4 discusses mechanisms to decrease the costs of MAS. The medical aid industry's need to conduct its own enforcement and inspection visits for each registered private facility is a significant cost driver and reflects lack of trust in the quality of the current enforcement system. Moving toward a high-quality, singular enforcement system will require considerable investments but will ultimately benefit the quality of care offered in the private sector as well as reduce costs for the medical aid industry.

3.5.3 EXPAND PARTNERSHIPS, INCLUDING MOBILE, TO STRENGTHEN PRIMARY HEALTH CARE

As described in Section 3.4, the MOH has invested considerable resources in strengthening tertiary care through public facility improvements. Section 3.4.2 proposes a likely market gap in the provision of low-cost primary health care services in rural or remote areas. Both national policy documents and long-standing experience in partnering with the private health sector for the provision of ART (and as of 2013, for the provision of tuberculosis care) suggest a strong commitment to PPPs for curative service delivery. However, MOH investments in tertiary, treatment, and specialist care may have limited more recent attention to preventative care and increased reliance on NGOs, many of whom are donor funded, for the provision of HIV prevention services. Prevention of noncommunicable diseases like diabetes is a growing area of concern for the public health of Batswana.

To address the gap in primary health care in rural and remote areas, the MOH has opened mobile clinics focusing on outreach services and immunizations. However, adequately staffing these clinics is a persistent challenge (Presidential Task Force, 2011). To alleviate sole responsibility for staffing as well as expand the number of mobile clinics in rotation, the MOH can pursue innovative PPPs for mobile outreach, which have been used successfully in Namibia

and South Africa in periurban and remote areas. Typically, mobile clinics focus on primary health care, with strong preventative services that include HCT, blood pressure screening, glucose testing, and basic vision testing. In Botswana, medical aid schemes and administrators may be interested in partnering with the MOH to outfit and administer mobile clinics. A PPP can be brokered whereby the MOH/CMS supply commodities to the mobile clinics free of charge, while the MAS can charge a small monthly subscription fee per user (set well under the rate of a typical MAS package). In addition, private corporations in Botswana can consider in-kind donations of vehicles or medical equipment to spur the creation of these clinics, while certain types of industries (e.g., farms, safari companies) can purchase mobile clinic access for their employees at a cost considerably lower than medical aid coverage.

3.5.4 BUILD ON MOH CONTRACTING EXPERIENCES TO MAXIMIZE THE USE OF EXISTING PRIVATE HUMAN RESOURCES

The oversaturation of private GPs in Gaborone, combined with underemployed nurses, may prompt qualified health personnel to pursue professional opportunities outside the country. As donor resources decline and state-of-the-art public health facilities remain understaffed, retention of human resources is crucial to sustaining the achievements in health care coverage. Compensation differences between public and private providers differ across the country. For instance, Francistown-based private GPs are experiencing growth, given less robust public investments, while many Gaborone-based private GPs are experiencing reduced profit. Contracting locally based health providers to work in public health facilities is one option to help augment private provider compensation, maximize the use of existing human resources, and encourage workforce retention in Botswana. Existing experiences and mechanisms in MOH outsourcing may offer a platform for contracting-in private physicians and public nurses to work within government health facilities. Below are two options to effectively utilize contracting to promote access to high-quality health services.

Contracting-in Private GPs in Gaborone to Work in Public Health Facilities

The high concentration of physicians in Gaborone has led to “crowding out” of private doctors due to steep competition among and between private and public providers. Yet, some urban hospitals, such as Botswana’s largest Princess Marina hospital, are oversubscribed, and other hospitals remain severely short staffed. Previously, when contracting-in private providers to work in public hospitals was explored in Botswana, the concept received little traction. But today, shifts in Gaborone’s health market that limit private sector growth and better facilities within the public sector have elicited a different response from private providers, who may now be more inclined to seize new opportunities for steady work. Private GPs could be contracted-in to provide services in public health facilities outside of normal operating hours. Extending services to evenings and weekends would provide patients with greater access to health services and would in turn help reduce pressures placed on overcrowded facilities like Princess Marina.

Interviews with private GPs revealed a willingness to work in public health facilities, particularly “after hours,” provided that reimbursement rates were acceptable and there was an ability to give input into the clinical implications of the contracting scheme (e.g., would the private GP have full autonomy in making clinical decisions?). Private providers are very cognizant that any clinical mishaps in a public facility would likely have implications in their ability to attract clients into their private facility. However, the lack of a viable association to represent private providers’ concerns on clinical matters in a contracting model weakens the likelihood of the widespread adoption of a contracting-in scheme by private providers.

The *Specialists Health Service Program* also offers an opportunity to build local capacity of public and private sector physicians. The specialists recruited into these programs may be more

recently trained, thus having fresh knowledge and skills. Contracting locally based physicians to work alongside these specialists would facilitate information sharing and the transfer of clinical skills. There are a number of considerations that such a program would need to take into account, including cultural differences, formal certification of new skills and knowledge, and clarifying the specialists' scope of work to include a training capacity. Through this type of twinning program, the MOH could help develop a pool of in-country medical specialists to work on a rotational or longer term basis in hospitals where gaps exist and specialty services are needed.

Contracting-in Nurses to Fill Shortages at the District Level

The scarcity of lower cadre health workers, particularly nurses who often serve on the front line of health care delivery, hamper the efficiency and use of tertiary-level care in both the public and private sectors. Discussions with private hospitals revealed that one of the major constraints to making optimal use of their facilities is inadequate levels of nursing staff. The platform of the *Specialist Health Services Program* can help attract, train, and retain much-needed nursing staff within Botswana. Pairing nurses with specialized physicians would offer a dual advantage – nurses would receive clinical exposure and build specialized skills, while foreign physicians would have the appropriate nursing support required to deliver high-quality, more efficient care.

Having nurses contracted-in to work alongside these physicians would help build a cadre of specialized nurses for Botswana who are able to serve in both the public and private sectors, and they could become integral support for private hospital growth. When the two-year term contract for foreign specialists is up for reconsideration, although they may choose to return home, having skilled nurses available would ensure consistency in care as new specialists rotate through the system. A stronger Nurses Association of Botswana that has the ability to assist nurses in filling spots in both public and private facilities would likely be an important component of a successful twinning program with nurses.

In summary, the above section discusses the private health landscape in Botswana through a description of the policy environment for the formation of PPPs; a retrospective, historical analysis of partnering with the private health sector; a detailed description of the size and composition of the private sector; and an assessment of key challenges facing private practice today. The section ends with a series of operational recommendations for strengthening the ability of the private health sector to maximize its contributions to providing quality health services for Batswana. Accessing the private health sector for services, however, is closely linked to the individual's capacity for financing those services. Section 4 discusses, in depth, options to expand private health care financing, both to increase patient ability to access services in the private sector and to ensure efficient financing sources systemwide in light of decreasing PEPFAR levels of contributions to Botswana.

4. HEALTH FINANCING

4.1 BACKGROUND: EXPECTED FUNDING GAP IN HEALTH

Botswana is preparing for significant reductions in its fiscal and external resources, which will have an unavoidable impact on its health care system. With an expected slowdown in the growth of mineral revenues, fiscal and corporate resources will unlikely grow sufficiently to cover the expected increase in the cost of health care. The announced reduction in donor funding for health (including, but not limited to, PEPFAR), will further widen the gap between needs and resources for health care. A number of key recent studies (Lee et al., 2012) have already examined possible public options to narrow the gap, including a one-point increase in VAT and various new levies.[1]

This PSA focuses on the private sector's options in attempting to narrow the health finance gap. These options include asking users to pay more for health care at point of service, requesting employers cover a larger share of their employees' health care costs, and expanding participation in MAS — the main actors in the health insurance system in Botswana. Although out-of-pocket (OOP) spending on health in Botswana is the lowest in Sub-Saharan Africa at 13 percent of private health expenditures, increasing OOP rarely constitutes a politically palatable solution, largely because the poorest members of the population are particularly affected by increased payments and may be unable to access needed health care as a result.[2] Similarly, in an environment where the private sector is likely to see its profits shrink due to the global economic slowdown, it would be unrealistic to expect most private companies to accept taking on a larger financial burden in order to increase their participation in the health care costs of their employees. Finally, while large numbers of Batswana are unable to cover the cost of their health care, many have sufficient resources to purchase health insurance, provided that this product meets their needs and offers good value. We therefore propose to focus this discussion on the opportunities available in Botswana to significantly increase participation in MAS.

4.2 CURRENT MAS COVERAGE IS IMPRESSIVE BUT SHOWS SIGNIFICANT ROOM FOR GROWTH

The health finance environment in Botswana is characterized by a relatively large number of MAS (see Annex C for details on each of the schemes). Botswana Public Officers' Medical Aid Scheme (BPOMAS) is the only MAS currently serving public sector employees and their families (although these employees are free to purchase coverage from other MAS, albeit without the benefit of a GOB subsidy). BPOMAS currently covers about 70,000, or 55 percent, of these employees. In the formal private sector, eight MAS currently serve about 70,000 employers and their families (34 percent of the formal sector workforce). The size of the MAS serving the formal private sector ranges from around 35,000 members for BOMaid to 9,000 for Itekanele, and presumably about 300 for even smaller MAS. This coverage level leaves about

[1] Private health expenditures do not take place in a vacuum. The levels and dynamics of public funding of health represent the background and, often, the incentive framework for private health expenditures. Please refer to Lee at al, (2012) and the recent National Health Accounts (Ministry of Health of Botswana 2012) for detailed data on public expenditures on health.

[2] Out-of-pocket payments for health (as a proportion of all private health expenditures) in Sub-Saharan Africa average at about 73%, ranging from 13% in Botswana and 14% in South Africa to 100% in countries such as Mali, Eritrea and Gabon (computed from World Health Organization data).

66 percent of private sector employees without coverage by any MAS. Although population size and MAS membership in the informal sector in Botswana are difficult to estimate, we believe that very few members of the sector's estimated 70,000 informal actors are covered by MAS (mostly through Itekanele and BOMaid).

The total number of employees covered by MAS is therefore estimated at about 140,000, which, assuming an average family size of 2.43, amounts to 340,000 lives covered, or about 17 percent of the total population of the country.[3]

Box 2. Medical Aid Schemes: Health Insurance or Not Health Insurance?

Opinions vary widely in Botswana as to whether medical aid schemes are actually health insurers, albeit by a different name. On the one hand, MAS act as poolers of risk and purchasers of medical services on behalf of their members, and are financed by (generally subsidized) premiums/contributions from their members. On the other hand, actuarial analysis appears to play a limited role in the setting of these premiums (community and income ratings are largely driving the levels of the rates, reflecting the original community, mutually supportive nature of the MAS movement in Botswana) with the result that pricing is only partially risk based. Some critics have suggested that avoiding the word "insurance" helps to ensure that MAS are not under the purview of the insurance regulator (although that future regulator, the Non-Bank Financial Institutions Regulatory Agency, clearly defines an insurer as "a person who undertakes liabilities by way of insurance, including general insurance, life insurance, and re-insurance, whether or not as a member of an association of underwriters, and includes a person operating a medical aid fund.") The fact that MAS are not-for-profit entities does not necessarily rule them out as insurers.

4.3 OPTIONS AND RECOMMENDATIONS FOR EXPANDING PRIVATE MAS COVERAGE

This report posits that one possible and feasible approach to bridging the expected gap in the financing of health in Botswana is to mobilize private resources through the expansion of coverage of MAS. Achieving this overall goal will require a focus on two broad interconnected subgoals: increasing the attractiveness of MAS products, and reducing their cost. The first subgoal will entail the development and effective support of a broader choice of insurance products operating in a regulatory environment that ensures industry stability while protecting consumer interests. The second subgoal will focus on strategies that aim to lower the cost of developing, distributing, and servicing MAS products to reach currently uncovered employees and their families.

More specifically, the report identifies the following five specific strategies to reach the goal of more attractive and more affordable MAS products:

1. Fewer, larger, stronger MAS
2. Lower cost insurance products and distribution channels
3. Modified plan choices in the public and private sectors
4. Supportive regulatory environment, including the resolution of supervisory concerns about collusion between and among MAS and providers
5. Stronger risk-sharing arrangements among the parties.

[3] This number does not necessarily suggest that the potential market for MAS in Botswana represents 83 percent of the population, for two main reasons. First, public facilities provide near-universal access to health care, and a proportion of the low-income population of the country is presumably satisfied with the public option or doesn't have access to private facilities at which they could use their MAS membership. Second, in order to attract the low-income population to MAS, premium subsidies would presumably have to rise above the current 50 percent, in effect using larger amounts of public sector resources in order to encourage private spending.

The bulk of this section discusses each of these strategies and concludes with operational recommendations that USAID may consider as options for health finance-focused technical assistance in Botswana.

4.3.1 FEWER, LARGER, STRONGER MAS

Nine MAS are currently covering about 140,000 employees (340,000 lives) in Botswana, or about 16,000 principal members per scheme. Since the three largest MAS (BPOMAS, BOMaid, and PULA, in decreasing order) provide about 88 percent of this coverage, the situation results in a relatively large number of small risk pools that individually do not exhibit the critical mass necessary to spread risk sufficiently and thereby lower their operational costs to more efficient levels. As a result, the MAS find themselves in a situation where they simultaneously need to increase their pool size but will not necessarily benefit from the cost structure necessary to do so. A smaller number of larger and well-managed MAS would lower the risk exposure of portfolios while leveraging more economies of scale. Both of these strategies would result in lower operational costs and, if these cost reductions are passed on to members, more affordable premiums.

While it may appear contradictory to suggest that an increase in MAS membership will first necessitate a decrease in the number of these organizations, the logic behind the argument suggests that any future increase in the number of MAS is more likely to be sustainable if it is based on lower costs and more attractive products, which are difficult to attain under the current industry structure. In other words, the number of MAS service providers may well have to shrink first in order for the MAS market to grow on a more sustainable basis. Whether or not the social, political, and commercial motivations behind the current structure of the MAS market in Botswana are compatible with the concept of merging schemes is an issue best discussed among stakeholders in the country, and is likely to have both proponents and detractors. However, there is little doubt that the likely alternative to the lack of voluntary scheme mergers appears to be attrition among those schemes, with no significant potential for market growth.

4.3.2 LOWER COST INSURANCE PRODUCTS AND DISTRIBUTION CHANNELS

Lowering the cost of insurance products and increasing the ability of MAS to reach youth and lower income populations more cost-effectively are essential to expanding MAS coverage.

In addition to the cost savings that could result from fewer and more efficient MAS (see Section 4.3.1), several product-related options could contribute to more affordable products. These options include lowering the cost (and benefits package) of products, attracting young people, and lowering product distribution and payment costs.

Experience in Botswana and abroad suggests that employees who are not currently covered may be swayed by products that provide limited coverage at a lower cost. These products, in order to both offer value to low-income clients and be sustainable for the MAS, should have the following characteristics:

- Cover essential primary care services and have a working referral system in place
- Provide limited annual health screening and encourage healthier lifestyles
- Rely on wide service provider networks contracted for provision of health services, which has the added benefit of limiting the risk providers face by guaranteeing a portion of their income[4]
- Where possible, use a capitation reimbursement model by actively encouraging

[4] This option is currently raising collusion concerns with the Competition Authority—see item 4 below.

beneficiaries to register with specific primary care practitioners/facility(ies)

- Allow coverage of chronic conditions (noncommunicable diseases and HIV and AIDS)
- Use cost-effective generic medicines
- As volumes increase, negotiate medicine pricing throughout the supply chain (manufacturers, wholesalers, and dispensing outlets)
- Explore and test hybrid insurance-savings products under which the less costly and more regular events (outpatient care) are financed through savings, resulting in less expensive inpatient-only products
- Explore the ability to upgrade coverage by adding specific elements (e.g., dental benefits).[5]

Currently, three so-called low-income MAS (LIM) – Itekanele, Doctors' Aid, and Etudiant – are providing products that combine some of the elements listed above. Although these LIM feature high loss ratios (sometimes above 100 percent), no current data in Botswana show that low-income products are necessarily less profitable than middle-income products, suggesting that the limits to the sustainability of LIMs may have more to do with low volumes, reputational effect of partial reliance on public sector care, and cost control issues.

Four of the remaining six MAS – BPOMAS, PULA, BOMaid, and Botlhe – offer products that have some similarity to LIM products, but so far none of these MAS have deployed significant efforts in reaching low-income workers. Given their solid financial base, these MAS may realize that they have the opportunity to develop attractive products and processes that are specifically designed with the low-income market in mind.

Although it is unlikely that current MAS members will choose to switch en masse to these "no-frills" products (especially since these members' premiums are often partly subsidized by their employers), some degree of membership realignment may be expected. In addition, rigorous market research may confirm that the downward expansion of MAS product lines may attract participants who are open to limited coverage in return for affordable premiums.

Small risk pools are especially sensitive to the aging (and the resulting worsening risk profile) of their members. Attracting **young, healthy people** to these risk pools is one way to counterbalance this effect, broaden the risk spread, and reduce the cost of the insurance products. Reaching this population requires a deliberate design, pricing, and marketing strategy that takes into account the needs and preferences of the target population. Possible areas of attention include the following:

- Design products that are more likely to meet the health needs of young people than the current benefits package does, such as by including health and wellness programs;
- Consider that the prevailing strategy of pricing products according to community-gauged affordability and income profiles results in products that are more expensive for low-risk members (such as youth) than products that are priced according to age and risk profiles;
- Expand the use of product distribution, payment, and servicing channels to include technologies that young people are comfortable with, particularly the Internet and mobile phones.

[5] We are grateful to Duncan Thela for his contribution to this analysis.

Lower cost distribution and payment channels are also key to reaching other categories of uncovered populations, specifically lower income employees in the public and private formal sectors, and in the informal sector.

Nascent efforts to sell insurance outside of the workplace (e.g., in supermarkets) may facilitate new enrollment, especially if combined with mobile technology for premium payments. Itekanele sells its product through teams of sales agents (paid on commission) that travel from town to town outside of Gaborone to market the insurance product at group meetings announced in advance by radio or letters to local leaders. This approach should be monitored to ascertain success and possibly be replicated.

Selling insurance products outside of the workplace means that premium deductions at source (through direct payroll deductions) are not an option. According to a recent report by FinScope Botswana, 41 percent of the population had access to a bank account in 2009; consequently, direct debit from policyholders' bank accounts is a possible option for automatic payments of premiums (Jefferis and Kenewendo, 2009). However, turnover in bank clientele is reportedly high, and may adversely affect the efficacy of this premium collection method (ibid.).

Since the main reason a person does not hold a bank account is the lack of regular employment, the MAS industry will need to identify non-bank-based methods to collect premiums to successfully attract members who work in the informal sector (ibid.). Selling insurance to the informal sector through grassroots organizations such as microfinance institutions and cooperatives does not appear to hold much potential in Botswana since these organizations currently have limited reach and their members appear generally satisfied with the public options for care already available to them.

Finally, innovative product features such as cash-back payments to policyholders who do not file claims are increasingly considered by MAS, and may play a role in attracting new members to the schemes.

4.3.3 MODIFIED PLAN CHOICES IN THE PUBLIC AND PRIVATE SECTORS

Increasing MAS coverage can be accomplished through two main channels. The first channel, discussed in the previous sections, relies on increasing the attractiveness and lowering the cost of insurance. These strategies would attract employees who previously did not find sufficient value in the concept of health insurance to justify purchasing it – even at subsidized rates. The second channel is to make health insurance a condition or a benefit of formal employment.

The GOB is in a particularly favorable position to use both of these channels to boost MAS coverage for public sector employees. Currently, public sector employees interested in joining an MAS only have BPOMAS as a main choice (although they can, if they choose, purchase coverage for their families from any of the other eight MAS). Increasing the choice of benefit plans to public sector employees may increase net enrollment if the resulting benefits package and premiums are more attractive to uncovered public sector employees than BPOMAS' current offering.

The second, even more decisive, option at the GOB's disposal is to make MAS coverage compulsory for all public sector employees – either under one BPOMAS administrator or through competition among MAS administrators. Since the GOB is currently subsidizing at least half of the premiums of all public sector employees who choose BPOMAS coverage, this option would represent a significant fiscal burden, especially as the subsidy rate would likely have to increase to near 100 percent to cover public sector employees at the lower end of the salary

range.[6] The Ministry of Finance is reportedly interested in exploring this option and public sector unions would likely insist on playing a part in the stakeholder engagement. Since the GOB has both the authority and the financial means to install mandatory health insurance in the public sector, this option represents the "lowest hanging fruit" to increase MAS coverage in Botswana. Indeed, it cannot be overemphasized that the existence of BPOMAS, with its relatively solid financial standing and reported capacity to expand, represents a uniquely strong basis for expanding coverage across the population of Botswana (although manageability of a much larger BPOMAS would probably require the combination of central pooling with decentralized management functions).

Although the number of uncovered employees in the private sector is larger than in the public sector, the option to make health insurance legally compulsory in the private sector would most likely meet with significant resistance from private employers.[7] Such an expansion of coverage under the current model of premium subsidy and MAS might represent a significant financial burden for private companies already concerned about the international and local economic outlook. Consultations with the Botswana Confederation of Commerce, Industry and Manpower and similar organizations might have to be undertaken to gauge the private sector's interest in this solution.

4.3.4 SUPPORTIVE REGULATORY ENVIRONMENT

A well-designed and impartially enforced regulatory framework for the provision of health insurance has the potential to facilitate greater financial stability of schemes, higher client protection, risk-based premiums, and accumulation of reasonable reserves. These outcomes, in turn, can affect the solidity and cost structure of the industry, increasing its readiness for expanding coverage. To the extent that the regulator has access to the legislative authority and the administrative tools to ensure that MAS are financially sound, it can protect the MAS' members' contributions and their access to care. At the same time, supervisory involvement in the setting of premiums and reimbursement rates has the potential to limit both increases in member contributions and medical inflation. Finally, a close monitoring of MAS' reserve accumulation has the potential to translate into lower premiums. Thus, questions were raised a few years ago about the size of BPOMAS' reserves – and the signals they sent about the financial appropriateness of member contributions – when the MAS was able to accumulate sufficient reserves to co-finance the building of a new hospital (i.e., now known as Bokamoso).

The Non-Bank Financial Institution Regulatory Authority (NBFIRA) Act of 2008 put the supervision of MAS under the purview of the Authority, but specific legislation to deal with financial soundness, consumer choice, and consumer protection has yet to be written. According to the NBFIRA Annual Report of 2011, "*Currently, Medical Aid Funds (MAFs) are defined as insurance companies in the NBFIRA Act. However, NBFIRA is currently in consultation with the MAF industry to determine the most effective way of regulating and supervising the MAF industry, that is, to either regulate them as insurance companies under the Insurance Industry Act or to draft separate regulations in order to regulate them in the current set-up as MAFs. To this end, NBFIRA has started a project with an overall objective to determine the most effective regulatory framework for the regulation and supervision of Medical Aid Funds ("MAFs") by NBFIRA. This covers the assessing of the current MAFs industry setup and determining the advantages and disadvantages of drafting a new legal framework, which*

[6] Arguably, the correct comparison would be between the current cost of providing care through the public sector and subsidizing MAS participation by the same population – the latter of which is likely to be less resource-intensive.

[7] The sectors that are likely to represent the largest potential market for MAS with respect to low-income insurance products are wholesale and retail, construction, manufacturing, other community services, hotels and restaurants, and agriculture.

introduces Regulations and Rules for MAFs, or to transform the MAFs into insurers as defined by the NBFIRA Act to underwrite health insurance. A consultant will be engaged to work with the relevant stakeholders and NBFIRA in developing the legal framework to regulate the MAFs" (NBFIRA, 2012).

KPMG Consulting has recently issued a report providing recommendations on the process, and stakeholder consultations are ongoing. Legislation is expected at the end of 2013 or early in 2014. While most MAS see the value of an enabling and progressive regulatory environment, questions remain as to the capacity of NBFIRA to effectively regulate MAS due to its lack of exposure to the health industry – and as to the level of services that MAS can expect in return for the regulation fee that they would need to contribute to the cost of that regulation.

An appropriate-touch regulation and supervision of MAS through NBFIRA presents the opportunity to:

- **Strengthen the financial stability of the industry**. Solvency regulation will protect members against the risk that MAS might be unable to meet their financial obligations. This enhanced stability, in turn, provides a solid basis for the industry to attract, serve, and retain policyholders.
- **Rationalize the setting of premiums and tariffs**. Requiring MAS to rely on minimal actuarial standards (while retaining some aspect of community rating) may incorporate additional risk considerations in the pricing of the products. Although these contribution levels may not necessarily and initially be lower than current ones, they have the potential to strengthen the risk profile and the stability of the industry – helping to ensure continued access to insured health care. Not surprisingly, although MAS and providers have different opinions as to whether reimbursement rates (also known as "tariffs" in Botswana) are too high or too low to ensure MAS sustainability and quality of care, all parties seem to agree that the current rate setting process is not functioning well (see discussion of Regulatory Authority concerns about collusion below). A regulatory process would offer the opportunity to consider different approaches to rate setting, including that used in South Africa, where the regulator sets the minimum reimbursement rates, and providers negotiate with MAS how much of a margin is added on top of the official rates.
- **Consider limiting the size of the MAS market**. Although the role of a regulator is to encourage competition, previously discussed concerns about the relatively large number of MAS in relation to the market size in Botswana may lead to calls to limit the entry of new insurers via regulatory means. At a minimum, and to the extent that the number of actors involved has a demonstrated impact on the financial stability of the industry, NBFIRA may want to consider increasing its scrutiny of the capacity, finances, and practices of new entrants. To support this recommendation, one of the smallest and most vulnerable MAS indicated to SHOPS that new entrants have copied its products – and even its marketing materials – in an attempt to capture their MAS market share.

The Competition Authority, established in April 2011, has indicated concerns about what it sees as potentially damaging collusion in the medical aid industry. Its first concern relates to collusion among providers in the process of negotiating reimbursement rates with MAS. As a result, the authority has indicated that MAS can only negotiate with providers on an individual basis, which raises administrative costs, damages trust between MAS and providers, and does not necessarily result in lower rates than if these were negotiated on a collective basis.

The authority's second, and closely related concern, relates to the empaneling of providers into networks tied to a specific MAS. One option to reduce the cost of medical insurance is to limit patient choice to a network of preapproved providers. Since such empaneling provides some

level of financial predictability and security to providers, the providers generally agree in return to lower reimbursement rates, which can be reflected in lower member contributions (this approach is widely used in developed countries). The Competition Authority has expressed its concern that such empaneling also increases the risk of collusion between providers, to the likely detriment of MAS and their members.

While the Authority is clearly and justifiably concerned with the impact of collusion risk on customer choice and prices, it may want to consider further how the loosening of its regulatory decisions on this specific issue may actually benefit consumers through channels that are specific to medical insurance.

4.3.5 STRONGER RISK-SHARING ARRANGEMENTS AMONG THE PARTIES

Risk sharing is an essential element of well-functioning health insurance systems. Disequilibria in the distribution of risk affect incentives, behaviors, investments, and, ultimately, access to insured care. If providers are not able to cover their costs with the insurance reimbursement, they may decide to ask policyholders to make up the difference between their fee and the insurance reimbursement rate (known as balance billing), or give priority to cash-paying patients. If reimbursement rates are higher than the costs to the provider, the latter may be tempted to provide too many services (in which case a capitated payment method may be preferable to better balance risk between provider and insurer, but evidence is currently lacking as to the viability of capitation in Botswana). From the insurer side, if reimbursement payments are too high compared to premium income, the MAS solvency will be weakened, with a long-term effect on the MAS' ability to provide insurance services without raising contribution levels. If, on the other hand, reimbursement payments are too low compared to premium income, this may be an indication that premiums could be lowered – and coverage increased – without affecting the financial health of the industry.

Perhaps not surprisingly, providers and MAS have different views about the implications of the current reimbursement levels on quality of care and insurance coverage in Botswana. While such a tension is to be expected in any process of setting reimbursement rates, the situation in Botswana is complicated by two factors. As mentioned earlier, the Competition Authority's concerns about collusion among providers prevent collective negotiations on reimbursement between provider associations and MAS, which inevitably leads to incomplete information sharing and limited trust between the parties. The lack of costing information from an impartial source contributes further to this situation. It is expected that the current effort by the Futures Group to cost a package of essential services will partially unlock the current situation regardless of whether these data are ultimately incorporated by NBFIRA in an effort to establish set mandatory minimum rates for the industry (see Section 4.3.4).

The patient's share of risk is another element that directly affects access to care. Currently, copayments that are inclusive of VAT appear to serve as a barrier to care, in particular for inpatient care, and, indirectly, to MAS coverage. Anecdotal evidence suggests that some MAS members are choosing not to activate their insurance and to go to public facilities for treatment because they cannot afford the copayment, and as a result crowd out uninsured patients in these facilities (as discussed in Section 3, this observation helps explain why Princess Marina is the only overstretched hospital in Botswana while others show significant unused capacity).

Copayments are a solidly established element of risk and cost control in health insurance. By forcing policyholders to cover a small portion of the cost of their care, copayments limit incentives for overutilization of services and, in the process, instill a sense of shared responsibility over the appropriate level of care. As their size in relation to the cost of care increases, however, copayments can increasingly serve as a deterrent to policyholders actually using their insurance to pay for care. In turn, knowledge about the levels of copayment can

dissuade currently uncovered people to join any MAS since they may fear being unable to afford copayment when they need to use their insurance.

Copayments in Botswana are set by different MAS at different levels, ranging from 0 percent to 22 percent. The Ministry of Finance collects 12 percent VAT on medical services, while the health care service provider collects the 10 percent usual copayment rate.[8] MAS decide whether to pass on none, part, or all of these two combined rates to their members. Since the rates are fixed by MAS and apply equally to outpatient and inpatient care, the deterrent effect is less of a concern for access to the former type of care than to the latter.

Opportunities to address this issue include considering imposing copayments as affordable lump sum amounts (instead of fixed percentages) – at least for inpatient care – revisiting whether MAS' financial health allows more schemes to absorb the copayment and/or the VAT, and advocating for the Ministry of Finance to remove VAT on health care services. Botswana currently has no VAT on medicines, thus providing a relatively strong precedent that should support the argument to extend this exemption to general health services.

4.3.6 ENGAGE LOCAL STAKEHOLDERS TO CATALYZE MAS STRATEGIES

This section concludes with a series of operational recommendations to begin the process of catalyzing the strategies discussed. First, we reflect on the discussion with key stakeholders during the PSA who advised that if the strategies discussed above are deemed valuable, they must be brought to the attention of high-level policymakers in the GOB, particularly in the ministries of health and finance. Given the many public bodies and regulations involved in the strategies we discuss, buy-in and discussion at a high political level is required.

Second, we propose convening and supporting a number of consultations between various categories of principal actors involved with medical aid in order to advance the resolution of some of the issues identified in this section. These actors are the following:

- Ministries of health and finance to consider plans to:
    - Expand MAS coverage to all public sector employees, by making coverage compulsory and/or opening up coverage to competition between MAS
    - Extend VAT exemption to medical services.
- NBFIRA and its counterpart agency in South Africa to identify simpler modalities of provider reimbursement rates
- Competition Authority, Medical Private Practitioners Group, and MAS in order to increase communication and meaningful negotiations on reimbursement rates between providers and MAS, and to empanel providers into networks tied to specific MAS – in both cases addressing the authority's concerns about collusion.

Given the complexities and business and political dimensions of the issues and strategies discussed in this section, consultation and discussion are key to the advancement of our recommendations to increase MAS coverage.

Finally, we propose two areas where USAID could provide the technical assistance needed to support interim steps that would eventually increase MAS coverage levels. One area of support is in the design and distribution of low-cost insurance products that could help incentivize and offset the costs to MAS in developing, testing, and monitoring low-cost products that could appeal to new segments of the population and ultimately increase coverage. In addition, USAID

[8] The origin of the 10 percent copay rate, charged by all MAS, is unclear. It is not a legislated rate, and its level may be more a function of practices inspired by other southern African countries than the result of recent actuarial calculations on the basis of Botswana-specific data.

could consider funding actuarial expertise and analysis for risk-based calculations of MAS premiums and copay rates. Alternatively, multinational insurance companies may wish to partner with USAID on health sector activities and could consider using their actuarial expertise to support these calculations. In the following section, we will discuss how these calculations, particularly for services like SMC, are essential in helping to sustain priority PEPFAR investments through the private sector.

5. SUSTAINING PRIORITY INVESTMENTS IN HIV SERVICES

As discussed throughout this report, Botswana has made tremendous strides in responding to its HIV epidemic, through substantial investments in HIV treatment by the GOB, PEPFAR, and ACHAP. In this section, we consider how the private sector might play a greater role in sustaining these investments – particularly for NGO-led prevention services, SMC, HCT, and ART – in a time of donor transition in Botswana. In each section, we will offer a series of operational recommendations about the role USAID can play in strengthening private sector components of these essential services.

5.1 NGO SUSTAINABILITY

Currently, Botswana has more than 300 health-focused NGOs, with a heavy focus on HIV preventative services, including HCT, condom distribution, orphan and vulnerable children (OVC) care, and home-based care for AIDS illness. NGOs are particularly active in the provision of HCT. Voluntary counseling and testing (VCT) is offered in 16 stand-alone Tebelopele sites, and eight additional NGOs provide VCT services. These NGOs contribute heavily to annual HIV testing for approximately 150,000 Batswana. These NGOs are historically heavily donor funded, and many were created as HIV ravaged the country in the late 1990s and were strengthened during the initial PEPFAR investment into Botswana. Currently, these NGOs receive funding through donor contributions, MOH contracting, or small-scale grants from umbrella organizations. The largest funding source is through donors such as PEPFAR or ACHAP, although donor funding is rapidly decreasing. Although there are a few international NGOs present and/or incorporated in Botswana (e.g., PSI), in this section we will consider the unique circumstances of indigenous or local Batswana NGOs. In an effort to understand the broad landscape of linkages between NGOs and the private sector, we interviewed NGO umbrella organizations such as the Botswana Council of Non-Governmental Organizations (BOCONGO), to understand the needs of the sector overall.

Registered in 1995, BOCONGO serves more than 200 NGOs with a mission of "*strengthening the NGO sector through coordination, facilitation, advocacy and capacity building for our members*." BOCONGO views funding uncertainty as the key challenge hindering the ability of NGOs to sustain and expand their health services. BOCONGO receives funding through the $5.3 million PEPFAR-funded Maatla project (active until May 2016) to help sustain and strengthen civil society's capacity to support HIV and AIDS and other health service delivery. Maatla is PEPFAR's key initiative to help NGOs strengthen their operational capacity, learn essential skills in financial management, seek alternative sources of revenue, and create growth plans.

To date, Maatla and BOCONGO have had **limited experience brokering sustainable NGO commercial linkages**. Some NGOs engage in income-generation activities to cross-subsidize operations (e.g., growing and eventually selling vegetables) and Maatla has designed a twinning approach to match skilled workers from the commercial sector (e.g., accountants) with an NGO

for a skills mentorship. Many NGOs, as well as BOCONGO itself, have reached out to corporations for one-off corporate donations through the lens of corporate social responsibility. For instance, First National Bank Botswana donated a trailer to the Botswana Retired Nurses Society (BORNUS), and the upcoming BOCONGO PPP forum seeks to link Batswana corporations with NGOs seeking donations or skills mentorship. Another large Botswana NGO, the Botswana Christian AIDS Intervention Progamme (BOCAIP), is a national faith-based organization responding to HIV and AIDS from a Christian perspective, and is a leading provider of HIV prevention services in rural and remote areas throughout the country. Although BOCAIP has trained numerous private companies in HIV prevention over the past 10 years and has sometimes received donations in return (and sometimes not), the organization does not sell its prevention and training services to private companies.

The remainder of this section considers prospects for commercial opportunities between NGOs and private corporations from the viewpoint of both sectors. These commercial linkages can help diversify revenue and cross-subsidize operations for certain NGOs, while providing a necessary health service to private employers in Botswana.

5.1.1 CORPORATE DEMAND FOR HEALTH AND WELLNESS SERVICES IN BOTSWANA

The first step in understanding prospects for NGO commercial linkages is to ascertain corporate demand for health and wellness services in Botswana through targeted market research. Illustrative interviews with corporate wellness managers and their representatives (e.g., BBCA and the Botswana Power Corporation) reveal that larger corporations currently tend to contract out health and wellness services, including HIV prevention, to for-profit peer education and training firms. In addition, certain large Batswana NGOs, like Tebelopele, have been hired by corporations to perform on-site HCT. Although Batswana corporations have provided a robust HIV preventative service offering to their employees (in response to the epidemic and guidance from organizations like BBCA), more and more employees are requesting holistic health and wellness services, such as stress management, financial management, blood pressure screenings, nutrition counseling, and diabetes prevention. Companies report a degree of “HIV fatigue” amongst employees even though HIV prevalence in the workplace remains high.

With demands from employees for broad and holistic health and wellness services, some companies have chosen to contract out services with multiple providers, including for-profit entities specializing in noncommunicable disease prevention or debt management. These multiple contracts are time consuming to procure, costly to manage, and vulnerable to executive committee decisions to reduce expenses and cut a component of the wellness program. Overall, it is appealing to companies to have one service provider that can offer a variety of health and wellness services, including HIV prevention, stress and financial management, and noncommunicable disease prevention and screenings. Traditional HIV-focused NGOs, with their long-standing experience in counseling and training, may be able to offer a broad array of services to corporations if they repackage and reframe their services and receive adequate skills-building assistance in these newer health and wellness topics.

In addition, there may be other market opportunities for NGOs, including competing against MAS administrators for disease management services or providing low-cost health services directly, which are more difficult to operationalize but are likely to be larger in market share than health and wellness services for corporations.

5.1.2 LANDSCPAPE OF INDIGNEOUS BATSWANA NGOS

The next step in ascertaining prospects for NGO commercial linkages is exploring and quantifying the ability of Batswana NGOs to provide those services desired by corporations for

their employees. The Maatla project, already closely working with NGOs in Botswana, is well-positioned to help understand the key components of NGO capacity to provide services to corporations. In order to deliver smooth and professional services to corporations, NGOs need the following:

1. **Urban presence and reach –** Most Batswana NGOs have more experience in working in rural settings than in the largely urban locations of Batswana corporations. Those NGOs (e.g., BORNUS, BOCAIP, and Tebelopele) that have a strong urban presence are at an advantage; however, the predominantly rural reach of most NGOs provide needed HIV preventative services to rural and remote populations.
2. **Marketing skills –** In order to pitch a service offering to a corporation, NGOs need pithy, effective, and compelling marketing materials that differ in tone, style, and length from traditional proposals for donor funding.
3. **Adequate management systems –** In order to effectively deliver services to corporations, NGOs need to have accurate monitoring systems, as well as billing and invoicing systems that meet corporate scrutiny and standards.

In addition, a thorough landscape analysis may reveal other types of existing creative NGO corporate linkages that could be monitored and possibly replicated. For instance, ChildLine, a Batswana NGO providing crucial care services to OVC and abused children, has a call center within its headquarters that has additional capacity for more call center counselors. Even if ChildLine does not wish to enter the market of offering health and wellness counseling to corporations given the distance from its mission of providing care for vulnerable children, another NGO with a counseling and training focus could rent space at the center in conjunction with a telephone counseling service to offer such services to a corporation. In the process, ChildLine would receive additional revenue, while the corporations would benefit from having a Botswana-based health and wellness counseling service that would eliminate companies having to rely on more expensive South African telephone counseling services. In addition, ChildLine is considering opportunities to leverage its child care facilities and sell daycare and child assistance services to foreign embassies in Gaborone. This additional revenue source could help cross-subsidize the organization's important social mission of caring for the most vulnerable children in society.

5.2 SAFE MALE CIRCUMCISION

Like many countries in southern Africa, the Botswana MOH, as well as ACHAP and PEPFAR, has invested heavily in scaling up SMC since 2007 as a key high-impact biomedical HIV preventative service. The SMC program is led by the MOH, and ACHAP – a leading donor for the scale-up of SMC – currently supports SMC coverage in 10 districts. PEPFAR, through the Centers for Disease Control, supports the scale-up of SMC through capacity-building for public health care sites and providers, direct provision of services, and assistance to the MOH to develop systems for SMC quality assurance and monitoring and evaluation. By 2016, Botswana aims to circumcise 80 percent of its adult males.

Botswana, unlike neighboring Namibia and South Africa, has involved private health providers in providing SMC early in its response to HIV. Currently, in all 10 ACHAP-supported districts, private providers are trained in the procedure, are contracted-in to provide the SMC service during three annual campaigns, and are reimbursed at a per procedure rate (which is different than PEPFAR guidelines that do not allow for per procedure reimbursement).

There are 47,000 Batswana men with private MAS coverage in the target SMC age range (aged 15-49). Although this figure is approximately 10 percent of the total Botswana target of circumcising approximately 480,000 men by 2016, Botswana (like most southern African

countries) is behind in meeting its targets overall, and these 47,000 men covered by MAS may be “low hanging fruit” for the expansion of SMC. Clearly, leveraging the private health sector to deliver SMC for those 47,000 men relieves the public and NGO sectors of these clients, and provides men who are accustomed to accessing the private health sector for their health care a more familiar service delivery point.

5.2.1 INACCURACIES IN THE UTILIZATION OF THE MAS STRUCTURE TO PROMOTE SMC

As described in Section 4, MAS in Botswana do not cover a standard set of prescribed minimum benefits, as in neighboring Namibia and South Africa. Thus, in Botswana, MAS can individually elect to cover SMC as an HIV preventative benefit. Currently, BPOMAS, PULA, and BOMaid cover SMC, and the negotiations to cover SMC as a HIV preventative benefit have largely been driven by AFA since 2010. In addition, due to the collusion considerations and lack of actuarial analysis undergirding MAS tariffs (both factors are described in detail in Section 4), widespread dissatisfaction exists among private providers concerning the current SMC tariff (or reimbursement rate) that the three largest schemes have in place. Discontent around the tariff rate is leading to some negative consequences, including perceptions by donors that private providers are “*not interested*” in providing the SMC service and a relatively low uptake of SMC in private facilities. Currently, the average SMC tariff in Botswana is significantly lower than the national tariff rate in neighboring Namibia (which was established through extensive actuarial analysis supported by USAID/Namibia) and thus suggests to the PSA team that the lack of actuarial inputs and activity-based costing used in Botswana may have led to the costs of performing the service in the private sector according to national guidelines (e.g., with adequate post-operative counseling) being underestimated.

5.3 HIV TREATMENT

This section discusses how a confluence of changes, including in the distribution and warehousing of medical products, in the future of the PPP ART model, and in the presence of donated ARVs through Merck, will alter the landscape for the private sector in HIV treatment.

5.3.1 CONTRACTING OUT DISTRIBUTION AND WAREHOUSING FOR MEDICAL PRODUCTS

CMS currently owns 15 vehicles for distribution of its products, but maintenance and repair of these vehicles is managed by the Central Transport Authority (CTA). At present, major bottlenecks within CTA create long delays in vehicle repair – at one point only four CMS vehicles were operational. The challenges with CTA are systemic, and options to contract out the management of all of government-owned fleet to a local private courier service are under discussion and would extend to warehousing and distribution under CMS. If implemented, contracting out these functions could prove promising in mitigating some of the serious inefficiencies in CMS distribution. However, this approach would have to be carefully monitored as the selected contractor may be unfamiliar with special requirements, such as handling, stocking, and packaging, that are often applied to pharmaceuticals and other medical products.

5.3.2 MOH TENDER FOR PPP ART MODEL EXPECTED TO END

This PPP model currently delivers ART to 14,000 patients through commercial channels. CMS finances and procures ARVs for the program while BOMaid manages the care of uninsured patients through participating for-profit providers. Although the program has been successful in extending ART provision throughout the scale-up response, it is perceived to be too costly. Hence, plans for its continuation after 2014 remain unclear as the MOH considers transferring

these patients back into the public health system. Decisions on whether to continue the PPP ART program should consider the following:

- **Recent adoption of new WHO guidelines expanding ART eligibility requirements from CD4 250 to 350 for HIV positive adults**[9]*.* With adult HIV prevalence at 23 percent, more people are now able to access treatment at an earlier stage of infection, thus increasing HIV patient load within public health facilities. If the new guidelines are applied, it is estimated that 32,000 new patients should have initiated ART starting in 2012 (Stegman et al., 2012). A recent costing study revealed that with the new guideline change, it may take three to four years for the additional pool of patients entering into the health system to level off.
- **Capacity of the public sector logistics and distribution system to manage and deliver necessary medicines for additional patients***.* The ability to effectively and efficiently manage ART patients, which includes the reliable packaging and distribution of medications, has been a key strength of the PPP model. Present challenges within the public sector supply chain combined with additional changes expected in the near term may place an additional burden on the system to deliver medications without delays.
- **The shifting of 14,000 patients is most likely to be concentrated to urban health facilities**. The PPP model relies on commercial channels to deliver medicines and services to patients, suggesting that these patients are likely living in urban areas where private providers are located. New eligibility requirements are already increasing demand for ART within public health facilities and it is unclear whether capacity exists to take on treatment and care for an additional 14,000 patients. While this number is relatively small, it will be disproportionately felt by public health facilities located in Botswana's few urban centers.

5.3.3 MERCK ARV DONATIONS THROUGH ACHAP EXPECTED TO END

ACHAP's ARV donations are expected to end in December 2014 as part of an ongoing effort since 2010 to scale down drug donations. As the partnership has phased down, the MOH has been taking increasing responsibility over the last few years to procure generic ARVs. However, in 2012, the estimated value of Merck's medicine donations was approximately $25 million. This estimate represents the cost of branded medications; generic ARVs will cost far less than the current value of existing ARV donations. Nonetheless, for the MOH to assume this additional responsibility at a time when multiple concurrent transitions are already placing strains on limited financial resources is an important concern. This additional responsibility, and its associated cost implications, may impact the MOH's decision as to whether or not to continue the PPP ART model.

5.4 RECOMMENDATIONS FOR SUSTAINING KEY PEPFAR INVESTMENTS

5.4.1 EXPLORE OPPORTUNITIES TO BROKER NGO-COMMERCIAL LINKAGES

Overall, we believe that significant opportunities for stronger contractual arrangements between NGOs and corporations exist in Botswana. However, it is important to keep in mind that these corporate arrangements are not a panacea for the sharp reductions in donor funding these

[9] After the assessment, WHO issued new guidelines further expanding eligibility to CD4 500 for HIV positive adults. As of the writing of this report, the GOB had not announced a decision on adopting the new guidelines. Regardless, the same challenges identified with the previous expansion of eligibility requirements would hold true if the more expansive guidelines are adopted.

NGOs are experiencing, nor are they likely to equal in size the total amount of donor funding NGOs have historically received. Exploring further MOH/NGO contracting arrangements is an extremely important facet for sustaining crucial HIV-prevention investments, particularly given the MOH's focus on tertiary care in urban areas and not on preventative care in rural areas. The MOH has begun to pursue contracts with a select number of NGOs for HIV prevention, and this strategy is likely to be crucial for NGO sustainability. However, NGO commercial linkages are another useful strategy for revenue diversification and possible cross-subsidization.

Conduct Market Analyses for Both Demand and Supply

As mentioned in sections 5.1.1 and 5.1.2, fully understanding the types of health and wellness services corporations desire for their employees, the additional market opportunities that may exist, and the NGO's capacity to respond to those market needs, is an essential first step. However, there may be cost-effective ways to ascertain these elements, including working with the Maatla project to survey and interview its partner NGOs, holding a consultation event through BOCONGO's PPP forum, and working through the BBCA to survey and understand the health and wellness needs of its member corporations.

Implement Pilot NGO Commercial Partnerships Based on Market Analysis

After understanding where NGO capability meets corporate demand, a USAID-supported one-year pilot that matches one corporation with one NGO to provide tailored health and wellness services could lead to revenue diversification for the NGO and a high value health service offering for the corporation's employees. This pilot would likely require targeted technical assistance to the selected NGO in the areas of drafting, marketing and pitching a service offering, negotiating a fair and viable contract, monitoring and reporting on service outcomes, and billing and invoicing in a timely and accurate manner.

5.4.2 DEVELOP A MORE ROBUST AND ACCURATE REIMBURSEMENT FOR SAFE MALE CIRCUMCISION

Advocate for More MAS to Cover SMC as a HIV Preventative Benefit

Since Botswana does not use a prescribed minimum benefit system, each MAS must individually elect whether or not to introduce and cover SMC as an HIV preventative benefit. USAID-supported advocacy work with those schemes not currently covering SMC is an important step to help those schemes understand the importance of the service to the health of their members. In addition, USAID could help to subsidize the cost of marketing materials that would introduce MAS members to the new service and describe frequently asked questions about the procedure and the time needed for recuperation.

Support Actuarial Analysis for a More Accurate SMC Tariff

As described in Section 4, resolving collusion considerations and supporting actuarial analysis will likely have a variety of positive impacts for the expansion of MAS coverage. An additional benefit is the ability to negotiate directly with private providers on the actual costs of performing SMC and the deployment of actuarial support to validate and propose an accurate tariff for SMC. Inaccurate tariffs pose two risks: private providers are likely not to want to perform the service under MAS coverage, or they may cut back on the more time-consuming aspects of the service needed to maintain quality, including post-operative counseling and follow-up visits.

Consider Networking and Reinforcement Mechanisms for Private Providers Offering SMC

Financing challenges are not the only reason for low SMC uptake in the private sector. SMC is a time-consuming service for private providers when considering counseling and post-procedure follow-up visits. In addition, trained private providers require a certain critical mass of SMC

clients to both build and retain their clinical skills post-training and to make the service financially viable within their practice. Overall, it is probably more effective to have a smaller number of private GPs offering SMC in Botswana at higher volumes than the current larger pool of fragmented, disparate trained GPs. Networking and branding trained providers in SMC could help build a trusted service provision for SMC in the private sector (potentially branded as service providers in HIV prevention and male health in order to mitigate stigma against SMC) and ensure the critical mass of clients needed to incentivize private providers to provide a high-quality circumcision service. MAS could also help to publicize those branded SMC service delivery points in the private sector.

5.4.3 SUPPORT EFFORTS TO SCALE UP QUALITY PROVISION OF HIV COUNSELING AND TESTING SERVICES IN THE PRIVATE SECTOR

As described in Section 5.1, NGOs are heavily involved in the provision of stand-alone VCT. As donor funding for direct services continues to decline in Botswana, the provision of VCT may be threatened. Alternatively, the MOH may scale up contracting arrangements with NGOs to provide VCT in remote and rural areas. In addition, the private health sector may be able to provide higher levels of HCT than currently occurring through the robust private laboratory and pharmacy infrastructure described in Section 3. Many private laboratories and pharmacies in Botswana have the private counseling rooms required for high-quality HCT. However, the lack of a tariff under MAS covering the counseling components for HCT hinders the willingness of private pharmacists and laboratory technicians to provide the service. Similar to the discussion for SMC, independent actuarial analysis and MAS advocacy could support the development of an accurate tariff to cover the costs of HCT through the private sector. Simultaneously, USAID could support training private pharmacists in HCT to ensure that a quality service would be delivered to patients.

5.4.4 LEVERAGE PRIVATE SECTOR PROCUREMENT AND DISTRIBUTION CAPABILITIES TO SUSTAIN HIV TREATMENT GAINS IN LIGHT OF MULTIPLE UPCOMING TRANSITIONS.

A decade ago, exorbitantly high rates of HIV in Botswana attracted global support to help curb the epidemic. Through strategies that leveraged resources across multiple sectors, Botswana developed strong platforms for partnering with the commercial sector to help achieve universal ART coverage. Today, in a more fiscally constrained environment, donor transitions call for continued shared responsibility to effectively deliver health services. Partnerships with the commercial sector offer scope for managing new and upcoming challenges presently converging on the health system. The recommendations offered below emphasize areas where focused USAID investment can more effectively utilize the private sector to help strengthen Botswana's health delivery systems over the long term.

Conduct Cost Analysis for Outsourcing Procurement to a Third-Party Agent

As SCMS technical assistance phases down, CMS is expected to take on full ownership of its procurement processes (e.g., budgeting, product specifications, bidding/tenders, managing suppliers). Management and implementation of these complex functions require greater capacity than what currently exists at CMS. PEPFAR, through SCMS, could assist the MOH to explore and cost various options for contracting out procurement to a third-party private agent. Advantages of contracting out procurement to a third-party agent may include the following:

- More flexible terms — a purchaser with appropriate skills, expertise, and strong relationships with suppliers/manufacturers may be in better position to negotiate favorable arrangements (e.g., shipment schedules that can be adjusted to adequately reflect changes on the ground)

- Greater ability to hold suppliers more accountable for performance with enforcement of penalties for late deliveries
- Better efficiency — third-party agents would be held to certain performance standards and will already have built-in capacity and expertise to carry out essential functions within the procurement process.

Assess Implications to Revising Evaluation Criteria for Bids

Existing evaluation guidelines help sustain and grow local businesses; however, this may not be the most cost-effective approach for pharmaceutical procurement. The looming funding gap necessitates the MOH make more efficient use of limited available resources. An alternative option includes reserving a certain percentage of overall CMS "business" for local entities (currently this is at 50 percent), which would continue to favor local suppliers and allow flexibility in addressing challenges with underperformance. USAID could support an assessment of the implications of a criteria change, including the potential impact on local businesses.

Conduct Cost Analysis to Understand the Scalability and Expansion of the PPP ART Model

This model not only offers promise for scaling up ART, but could also be expanded to offer other health services (e.g., diabetes treatment) and products through private sector delivery channels. One of the major criticisms of the PPP ART program, however, is that it is too expensive. A cost-effective analysis would determine whether the MOH is receiving the best value for its money and help identify improvements that may better maximize program benefits. PEPFAR is currently supporting activities to cost various aspects of HIV and AIDS programming and could potentially build upon this effort by costing the PPP model. Cost data would also inform future budget allocation decisions for sustaining and/or scaling up the PPP to deliver other essential health services.

In addition, the MOH recently (May 2013) launched a Public Private Mix Framework for Tuberculosis Control to ensure that the diagnosis and treatment of tuberculosis in private health care settings is in compliance with the national guidelines and to help ensure the provision of quality and affordable tuberculosis case finding, diagnosis, and treatment services in private health facilities. Many of the same concepts raised in our analysis of the PPP ART model – representation of private providers for clinical discussions with the MOH, reliance on the public sector supply chain for essential commodities, and effective enforcement of clinical quality in the private sector – will influence the success of this PPP in tuberculosis control over the next few years.

6. CONCLUSION

This PSA describes the historic evolution, current composition, and future prospects of Botswana's private health sector in a time of tremendous change for the country. The recommendations aim to better leverage the private health sector in expanding essential health services; increase private health financing and MAS coverage; and sustain the tremendous achievements in priority HIV services made by the GOB, private providers, and PEPFAR over the last 10 years. Both the MOH and USAID can pursue many of these recommendations to help ensure strong shared responsibility for national health goals between the public and private sectors.

Although the audience for this PSA is intended to be in Botswana, the country's unique history of partnering with the private health sector to provide high-quality health services to its population, strong track record of good governance, and accelerated trajectory of economic growth can serve as an inspiration for other African countries. In addition, Botswana's position as a frontrunner in the PEPFAR transition offers a useful lens to understand how private sector strengthening strategies can help sustain investments made by donors and may offer ideas for consideration to other countries at a different stage of private sector development and at a higher level of PEPFAR dependence.

The recommendations vary in levels of complexity. Some recommendations, such as pursuing merger strategies for MAS, have high degrees of political and business ramifications and would require broad-based consultation and senior political buy-in to move forward. A successful resolution of such concerns, however, could yield strong increases in the expansion of MAS coverage. Other recommendations, such as brokering NGO-corporate linkages, may be easier to operationalize at a small scale but will have less impact on national implications. A balance of long-term and short-term recommendations, combined with national policy and singular organizational dimensions, are offered. Although Botswana's small population and its saturation of health care facilities in urban centers represent an important market barrier to private health sector growth, we are optimistic that the private health sector will remain an important provider of health care services. For instance, the market gap in low-cost primary health care in rural areas could be filled through innovative expansion by private facilities or clinical NGOs. Through effective stewardship by the MOH, targeted investments by donors, and strong representation by the private sector, the contributions of private health care providers will likely expand.

The goal of these recommendations, and ultimately of the PSA, is to assist the GOB, USAID, and the private sector in strengthening Botswana's already vibrant health care system and to more efficiently rationalize and deploy its existing strong resource base to prepare for a truly country-led and self-sufficient future. By thinking creatively, planning for the impact of multiple transitions, and effectively using evidence to consider the future of public-private engagement, Botswana's mixed health care system will continue to serve the evolving needs of its citizens.

ANNEX A: SCOPE OF WORK

This scope of work was originally drafted in late 2012 for review by the Ministry of Health. Both the timeline and details of the assessment focus evolved through discussions with key stakeholders in April 2013. See sections 1 and 2 for the final PSA goals and methodology.

Botswana Private Sector Health Assessment
Proposed Scope of Work

I. BACKGROUND

The Republic of Botswana is a stable, democratic country in Southern Africa with an estimated population of 1.8 million.[1] The country has maintained high economic growth rates while still confronting widespread poverty and critical health threats like HIV and AIDS.[2] Despite a downturn in 2009, gross domestic product (GDP) growth was 7.2 percent in 2010 and estimated at 6.2 percent in 2011. With sound fiscal management, Botswana has been able to transform itself from one of the poorest countries in the world to a middle-income country with a per-capita GDP of $16,300 in 2011. Much of this financial gain can be attributed to diamond mining, which currently accounts for more than one-third of GDP, 70-80 percent of export earnings and roughly half of the Government of Botswana's (GOB) revenue.[3]

Strong political will, consistent economic growth, and international donor support have produced one of the most developed public health systems in Africa. Health care services are easily accessible and generally free to all citizens. Improvements in health policy and infrastructure have resulted in an estimated 97 percent antenatal care coverage and 94 percent of deliveries being attended by a skilled birth attendant. HIV prevention and treatment efforts, led by the National AIDS Coordinating Agency (NACA), have resulted in antiretroviral therapy (ART) coverage of 80 percent of people needing HIV treatment, and Prevention of Mother to Child Transmission (PMTCT) services now reach 95 percent of pregnant women.[4] Most recently, a national Safe Male Circumcision strategy has been initiated to prevent HIV transmission and contribute towards the goal of zero new infections by 2016.[5]

Despite these gains, HIV remains the most significant public health problem in Botswana, and combined with other communicable diseases, is responsible for approximately half of all deaths in the country. Botswana has the second highest HIV prevalence rate in the world, though actual estimates vary by source. In 2006, a World Health Organization report suggested that 37 to 39 percent of adults 15-49 were HIV positive, while UNAIDS reported roughly one in four adults had HIV in 2007. Estimates also suggest that over the past five years, approximately

[1] Ministry of Health. 2011. *National Health Policy: Towards a Healthier Botswana*. Gaborone: Ministry of Health.
[2] National AIDS Coordinating Agency. 2010. *Botswana Partnership Framework for HIV/AIDS 2010-2014: A Collaborative Effort Between the Government of Botswana and the Government of the United States of America.* Gaborone: NACA.
[3] CIA. 2012. *The World Factbook: Botswana*. Washington, DC: CIA. Accessed 5 September 2012. <https://www.cia.gov/library/publications/the-world-factbook/geos/bc.html>.
[4] United Nations Development Programme. 2009. *Assessment of Development Results: Botswana*. New York: UNDP.
[5] Department of HIV/AIDS Prevention and Care. 2008. *Safe Male Circumcision – Additional Strategy for HIV Prevention*. Gaborone: Government of Botswana.

one-third of pregnant women have been HIV positive. As of 2009, 300,000 individuals were infected with the virus, with 160,000 in need of ART.[6]

Given the high prevalence of the disease, HIV has the potential to threaten Botswana's impressive economic gains and overburden public health resources, both human and financial. Severe shortages of trained health personnel threaten the quality of public health services. Unlike most countries in Africa, the Government of Botswana has historically financed the bulk of the national HIV and AIDS response. A 2010 UNGASS report estimates that roughly USD 348 million was spent on the national HIV response in 2008. Of this, 66 percent was from public sources; 32 percent from international partners; and 2 percent from private sources.[7] The 2012 report estimates total HIV spending dropped to USD 147 million in 2010, while noting that this figure represents an estimate using 2009 NHA data, and should thus be interpreted with caution.[8]

The Government of Botswana remains committed to ensuring that all people have access to affordable and quality health care services. Botswana is currently implementing the Second National HIV/AIDS Strategic Framework, the Tenth National Development Plan as well as health related goals contained in the national development blueprint, *Vision 2016*. Chief among key health policies is guaranteed access by all citizens to a package of essential health care services and the assurance of an equitable distribution of health resources and utilization of health services.[9] The country also has several medical aid schemes that fund health care, including HIV care and treatment. Different schemes are tailored for public and private sector employees, while one scheme specifically targets low income individuals. However, a recent National Health Accounts (NHA) report suggests that Botswana's population is too small to support multiple medical aid schemes and that they often represent a duplication of effort, increased administrative and information systems costs, and inequities in access to and utilization of health services.[10] Meanwhile, the National Operational Plan 2012-2016 suggests that to achieving the goal of zero new infections by 2016 will cost USD 979 million, with an average annual cost of USD 242 million.

In the past, Botswana has relied on international donors like the United States President's Emergency Plan for AIDS Relief (PEPFAR), and to a lesser extent, Merck, for ARVs. However, the current global financial crisis, combined with general declines in donor funding, indicate that Botswana may have to increasingly mobilize local resources – public and private - to sustain its HIV response and continue to ensure access to priority health services for its populace. The projected costs for achieving zero new infections, and the considerable gap compared to current funding levels, underscores this need.

These factors warrant increased consideration of the key role the private sector could play in helping Botswana continue to meet national health needs. The National Strategic Framework for HIV and AIDS 2010-2016 recognizes that strengthening private sector "participation in the national response offers an opportunity to tap into private sector expertise and other resources

[6] National AIDS Coordinating Agency. 2010. *Botswana Partnership Framework for HIV/AIDS 2010-2014: A Collaborative Effort Between the Government of Botswana and the Government of the United States of America.* Gaborone: NACA.
[7] National AIDS Coordinating Agency. 2010. *Botswana Country Report 2010.* Gaborone: NACA.
[8] National AIDS Coordinating Agency. 2012. *Botswana 2012 Global AIDS Response Report*. Gaborone: NACA.
[9] Botswana Federation of Trade Unions. 2007. *Policy on Health and Occupational Safe Environment in Botswana*. Gaborone: BFTU.
[10] Ministry of Health, Republic of Botswana. 2012. *Botswana National Health Accounts for Financial Years 2007/08, 2008/09 and 2009/10*. Gaborone: Ministry of Health.

in new ways."[11] The GOB has also developed a public-private partnership (PPP) framework to guide policy and legislation as well as standard procedures to guide the process for implementing PPPs. However, this framework has not been operationalized and efforts to coordinate a public-private response have come up short. A Development Partners Coordination Forum has also been created within the Ministry of Finance and Development Planning to establish a dialogue structure aimed at greater coordination between development partners and national stakeholders including civil society and the private sector. While the relevance of the private sector is noted, efforts to leverage private sector resources and promote efficiencies through greater collaboration are needed.

Gathering information to better describe and quantify the private health sector and their contributions to health is a critical first step in establishing cooperation between the public and private health sectors, leading to sustained public-private partnerships in health. The USAID-funded **Strengthening Health Outcomes through the Private Sector (SHOPS)** project is poised to address this need through conducting an assessment of the private health sector in Botswana. The proposed Private Health Sector Assessment (PSA) will be a collaborative effort between USAID/Botswana, the Ministry of Health (MOH) and other relevant stakeholders, with the goal of identifying opportunities for greater private sector engagement in the HIV response, and contributing to a stronger health system in Botswana.

II. GOAL AND OBJECTIVES

Goal

The ultimate purpose of the assessment is to identify and leverage private sector resources for health – whether financial, human or structural – and to facilitate greater public-private cooperation, with a focus on HIV and AIDS.

Objectives

To achieve this goal, the private sector assessment will:

1. Provide an overview of private health sector stakeholders and their respective roles;
2. Assess the level of policy dialogue between the public and private health sectors;
3. Describe private sector contributions to key health markets and health system areas, including health financing;
4. Identify existing and potential opportunities for public-private partnerships in health; and
5. Provide recommendations on how best to operationalize PPPs in the health sector.

III. APPROACH

SHOPS will convene a multidisciplinary team to conduct the private health sector assessment. Team members will be knowledgeable about the private health sector in Africa, and will be able to address the priority areas presented below:

- **Policy environment -** The team will review existing and draft legislation and the overall policy environment in Botswana to identify opportunities and potential barriers to greater public-private engagement in health.
- **Health financing -** Areas of emphasis will include contracting models and understanding the role of private medical aid schemes, particularly in light of discussions around National Health Insurance. The team will explore resource mobilization in the health sector, building

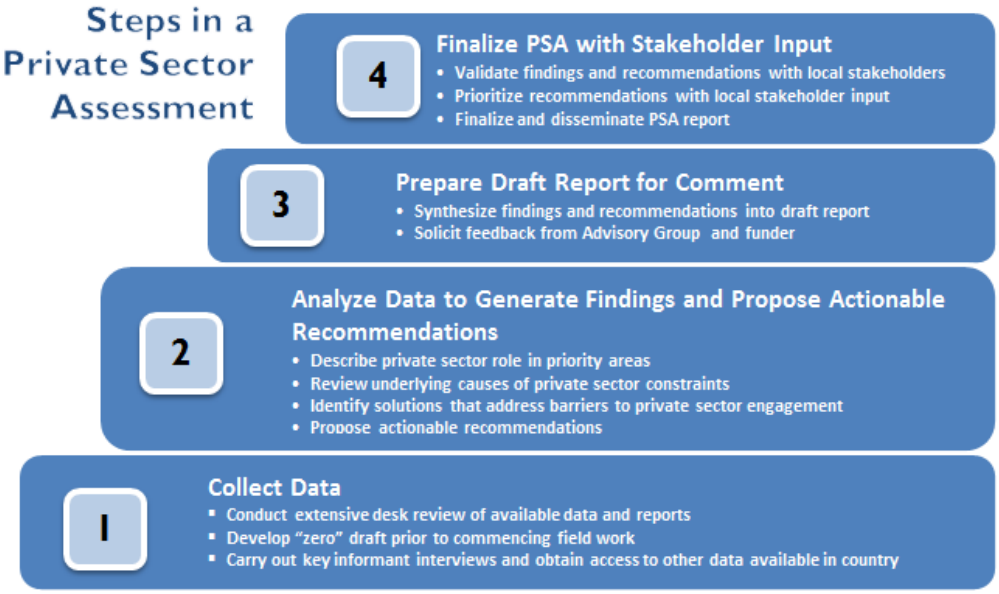
[11] National AIDS Coordinating Agency. 2010. *Botswana Partnership Framework for HIV/AIDS 2010-2014: A Collaborative Effort Between the Government of Botswana and the Government of the United States of America.* Gaborone: NACA.

on the resource mobilization strategy currently under development by the Health Systems 20/20 project.

- **Service Delivery –** Emphasis will be placed on assessing the demand for and supply of key health services from the private health sector, both for and not-for-profit. The team will examine the referrals both within the private sector and between the public and private sector to assess continuity of care, particularly related to HIV services.
- **Management of Pharmaceuticals and Medical Supplies –** Given existing challenges in forecasting and procurement faced by Central Medical Stores, the assessment will document the private supply chain, with a focus on HIV-related supplies and pharmaceuticals, to identify opportunities for an increased private sector role, as well as increased efficiencies in the system.
- **Male Circumcision –** The team will assess the degree to which the private for-profit sector is incorporated into national male circumcision plans and goals, both in terms of financing and service provision. Specifically, the team will examine the extent to which private Medical Aid Schemes cover male circumcision as a preventative HIV benefit; variance in reimbursement rates between schemes; and the degree to which private providers are currently offering male circumcision services. Lastly, the team will examine the appropriateness of the national male circumcision training curriculum for private providers and offer recommendations for effective training approaches for male circumcision for private providers.

SHOPS and its predecessor project, Private Sector Partnerships-*One* (PSP-*One*) have conducted more than 25 PSAs over the past five years, including several in sub-Saharan Africa. Many of these assessments have led to field-based programs designed to increasingly engage private sector actors in helping countries address priority health needs, often resulting in innovative programming and partnerships. As depicted in Figure 1, the typical PSA consists of four steps: data collection, data analysis, report development and validation by local stakeholders. Once the scope of work (SOW) is approved by key stakeholders, 1) the assessment begins with a comprehensive literature review and analysis of available data (such as DHS or NHA). This provides the team with a basic understanding of the landscape and context, as well as key challenges and gaps in information. This phase is followed by the field work, which entails targeted stakeholder interviews (representing both public and private sectors) and field visits to private sector facilities and initiatives. 2) The analysis step typically begins in-country, through nightly debriefings where the PSA team shares information, vets initial findings, and begins to form actionable recommendations. This process continues past the fieldwork, as the team integrates their respective findings, identifies opportunities for greater private sector involvement, and develops appropriate recommendations. 3) The next step is to synthesize findings and recommendations into a draft report, followed by 4) validating findings and recommendations with local stakeholder input, and disseminating the final report.

FIGURE 1. TYPICAL STEPS IN A PRIVATE HEALTH SECTOR ASSESSMENT



IV. DURATION, TIMING, AND SCHEDULE

The period of performance for the assessment will be approximately 6 months, including preparation time, in-country field work, report writing and dissemination. Dates for in-country data collection will be determined in consultation with USAID/Botswana and the MOH. Preliminary recommendations will be presented to the Mission as part of the PSA field team's exit briefing, and a draft report available for review within 6-8 weeks of the field visit. The chart below suggests an illustrative timeline of key activities typically involved in conducting a private sector assessment.

Activity	Oct. 2012	Nov. 2012	Dec. 2012	Jan. 2013	Feb. 2013	Mar. 2013
Planning						
Finalize SOW	X					
Identify team members	X					
Identify key stakeholders	X					
Schedule meetings with key stakeholders		X				
Literature Review and Question Development						
Conduct background research & document review	X					
Develop questions tailored to specific stakeholders	X					

Activity	Oct. 2012	Nov. 2012	Dec. 2012	Jan. 2013	Feb. 2013	Mar. 2013
Field Work						
Conduct stakeholder interviews		X				
Conduct field visits		X				
Debrief with key stakeholders		X				
Report Writing and Dissemination						
Develop outline for report			X			
Conduct analysis and draft report			X			
Vet preliminary findings and recommendations with in-country stakeholders				X		
Submit draft report to USAID and other key stakeholders for comment prior to dissemination				X		
Disseminate findings to local stakeholders					X	
Finalize report						X

VI. DELIVERABLES

In consultation with USAID/Botswana, the SHOPS project will produce:

1. Final Scope of Work that includes:
   a. Goals and objectives of assessment
   b. Team composition, roles, and responsibilities
   c. Timeline
2. Detailed plan for fieldwork that covers:
   a. Key questions by stakeholder group
   b. Schedule of interviews and site visits
   c. Schedule for USAID debriefing
3. Preliminary debriefing towards the end of the assessment trip to present preliminary findings and recommendations
4. Final assessment report
5. Pending sufficient budget, consultative in-country workshop to share findings and prioritize recommendations with key stakeholders representing the public and private sectors (in-country dissemination is often supported with local funding).

ANNEX B: KEY STAKEHOLDER INTERVIEW LIST

#	NAME	ORGANIZATION
Public Sector: Ministries and Government Agencies		
1	Bonnet Mkhweli	NACA
2	Dr. Molelekwa	MOH/Princess Marina Hospital
3	Dr. Ndwapi Ndwapi	MOH, Office of Strategy Management
4	Naledi Mlaudzi	MOH, Directorate of Health Policy Monitoring & Evaluation
5	Mr. Mathala	MOH, Directorate of Health Policy Monitoring & Evaluation
6	Mr. Tlogelang	MOH
7	Dr. Sinah Selelo	MOH, Drug Regulatory Unit
8	Yorokee Kapimbua	NACA
9	Lefetogile Bosigong	NACA
10	Phineas Sesinyi	NBFIRA
11	Boikobo Dishepeng	NBFIRA
12	Jane Alfred	MOH
13	Dr. Khumo Seipone	MOH
14	Peter Chibatamoto	MOH
Private Health Sector		
15	Kabelo Ebening	BBCA
16	Frank Mwangemi	ACHAP
17	Jerome Mafeni	ACHAP
18	Rachel Jackson	ACHAP
19	Mr. Molobe	Botswana Chamber of Commerce
20	Graeme Kendall	Life Gaborone Private Hospital
21	Hilda Mkwanda	Sister Nursing Service and Agency
22	Dr. Gordana Cavric	Gaborone Medical Centre
23	Dr. K F Mompati	Tati Clinic (Francistown)
24	Dr. N Hobona	Private Clinic (Francistown)
25	Dr. Mallya	Boipuso Surgery (Franscistown)
26	Dr. Nkomo	Ekusileni Clinical Laboratory
27	Mohammed Igbal	Diagnofirm
28	Rene Lombard	Sebele Pharmacy
29	George Siwale	PHC Chemist
30	Innocent Mupunga	Diagnofirm
31	Senthil Maran	Diagnofirm
32	Dr. Schichemenge	Delta Medical Center (Maun)
33	Dr. Chris Carey	MediHelp Clinic (Maun)
34	Dr. Ava Avalos	ACHAP/Private Practice
35	Denis Alexander	BOMaid
36	Dr. Lorato Mangadi	BOMaid
37	Ruben Naidoo	Bokamoso
38	Solly Reikeletseng	Itekanele Health Plan
39	Gaone Letshwiti	Itekanele Health Plan
40	Duncan Thela	AFA
41	Vishwas Divekar	Kalahari Medical Distributors, Ltd.

42	Ogona Tshosane	BHPC
43	Khumo Modisaeman	Nursing and Midwifery Council of Botswana
44	Bathusi Kgosietsile	Pharmaceutical Society of Botswana
45	Dr. Kerileng Moeti	Medical Private Practioners Group
46	Dr. F Museta	Medical Private Practioners Group
47	Dr. A Sibiya	Medical Private Practioners Group
48	Dr. Mashilaba	Former Medical Practitioners Association
49	Dr. Bagwato Sikwa	Seventh Day Adventist Church Hospital
50	Mrs. Kewakae	Botswana Retired Nurses Association
51	Bagaisi Mabilo	BOCONGO
52	Tapologo Kwapa	BOCONGO
53	David Ngele	Botswana Network of AIDS Service Organizations
54	Lebogang Makgekgene	Botswana Power Corporation
55	Onkemetse Montsheki	ChildLine
56	Rachel Monana Seago	ChildLine
57	Boipelo Tlogelang	BORNUS
58	Qinani Dube	Independent Consultant
59	Irene Kwape	BOCAIP
60	Patience Derera	Women's Finance House
61	Rose Tatedi	Symphony Health
62	Lesedi Keehle	Symphony Health
63	Minkie Bokole	PGC
64	O. Champi	Medswana
65	Piet Le Grange	Medswana
66	Mark Sallows	Medswana
67	Mpho Gaotlhobogwe	Medswana
Donor and Implementing Agencies		
68	Peter Stegman	Futures Institute
69	Dave Terpstra	Crown Agents/SCMS Project
70	Anthony Kinghorn	Health Financing Thematic Working Group
71	Ketlogetswe Montshiwa	FHI 360
72	David Brown	USAID
73	Monica Smith	CDC
74	Mavis Bengstsson	CDC
75	Ambassador Michelle Gavin	U.S. Embassy
76	Wandani Sebonego	CDC
77	Joan LaRosa	USAID/Botswana
78	Marlene Nkete	USAID/Botswana
79	Anthony Cotton	USAID/Washington
80	Richard Harrison	PSI
81	Irene Maina	UNAIDS
82	Richard Msowoyo	Crown Agents/SCMS Project

ANNEX C: MEDICAL AID SCHEMES

Eligibility	Management (Status)	Plans	# of Members (Contributions; Claims Paid)	Admin Costs	Reserves (Solvency Ratio)	Copay Amount
PULA						
Formal sector workers & public enterprises; open to informal sector	1 Board of Trustrees (Company reps and independents); administered by AFA (nonprofit)	**Standard** • P40,000 annual limit; Monthly cost based on income level range from P313 to P442 for principal members; P269 to P378 for adult dependents; P69 to P101 for child dependents **Deluxe** • P800,000 limit per year (includes P300,000 basic and P500,000 dread disease coverage) Monthly costs based on income level range from P807 to P995 for principal members; with variable cost for dependents. Discounts offered for employers with more than 10 staff • HIV coverage – SMC, plus P15,000 limit per beneficiary for ARVs, monitoring tests, CD4+, and viral load Discounting based on number of enrolled employees, with greater discounts available to companies that have more employees enrolled	15,964 principal members 37,195 including beneficiaries (P113.4M; P88.6M for FY10)	P16.2M (AFA charges 7.25% admin fee)	P68.5 M (60%)	10% copay 0% copay for deluxe enrollees if amount > P3,000 per event Scheme pays VAT
BPOMAS						
Civil servants (including members of parastatals that were formerly GOB agencies)	Government – board comprises senior government employee; administered by AFA (nonprofit)	**Standard** • Annual limit ranges from P13,500 (no dependents) to 18,500 (5+ dependents); Monthly costs based on number of dependents range from P96 (no dependents) to P176 (5+ dependents) • Does not include HIV coverage **High** • P185,000 annual limit (P85,000 basic and P100,000 dread disease coverage); Monthly costs based on income ranges from P117 to P251 for principal members; cost of additional dependents varies based on salary and number of dependents, with overall peak monthly contributions at P432 for individual with monthly salary of P3,000+ and 5+ dependents • HIV coverage – P,9730 annual limit per beneficiary for ARVs	69,029 principal members 166,267 including beneficiaries (151,352 on high benefits package) (P375.2M; P286.7M in FY10)	P49.9M (AFA charges 7.25% admin fee)	P645.0M (171.6%)	10% copay, Standard enrollees exempt from copay and P1,000 annual copay limit Members must pay 12% VAT

Eligibility	Management (Status)	Plans	# of Members (Contributions; Claims Paid)	Admin Costs	Reserves (Solvency Ratio)	Copay Amount
BOMAID						
Formal sector workers & public enterprises; open to informal sector	Employers and employees; administered by Southview (nonprofit)	**3 Corporate schemes** • Scheme A: Annual limits for individual/family of P261,090/ P276,926 • Scheme B: Annual limits for individual/family of P825,269/ P961,606; Monthly cost based on salary and number of dependents range from P515 to P1,739 • Scheme C: Annual limits for individual/family of P1,286,782/ P1,700,000; Monthly cost based on age and number of dependents range from P511 to P1,625 **2 individual schemes** • DS Standard: Annual limits for individual/family of P261,090/ P276,926; Monthly cost based on age and number of dependents range from P340 to P1,179 • DH High: Annual limits for individual/family of P801,314/ P926,471; Monthly cost based on age and number of dependents range from P511 to P1,625 HIV coverage for both scheme types purchased separately through Special Benefit Fund – covers ARVs and lab tests with monthly limit of P1,000 per enrollee	34,556 principal members 76,592 including beneficiaries (P340.1M; P288.8M in FY2011)	P41.8M	P264.3M (15.5 months claims cover in reserves)	22%, includes 12% VAT that members must pay
Botsogo						
	Administered by Momentum Botswana, subsidiary of Momentum Africa	**Diamond** (cost as of 2008) • Annual benefit unlimited for single and family plans. Includes 100% benefit, P15,850 limit per year for ARVs and lab tests for enrollees in HIV and AIDS benefit; Monthly costs for average family based on salary/dependents range from P777 to P1,413 **Platinum** (cost as of 2008) • Annual benefit unlimited for single and family plans. Includes 90% benefit, P15,850 limit per year for ARVs and lab tests for enrollees in HIV and AIDS benefit; Monthly costs for average family based on salary/dependents range from P468 to P923 **Copper** • Annual benefit unlimited for single/family. Includes 90% benefit, P5,450 limit per year for ARVs and lab tests for enrollees in HIV and AIDS benefit. **Gold** (cost as of 2008) • Annual benefit unlimited for Single/Family. No HIV benefit. Monthly costs for average family based on salary and dependents range from P360 to P645				Generally 0% copay HIV benefits in Platinum and Copper plans require 10% copay Alternative Diamond 10, Platinum 10, and Copper 10 plans offer

Eligibility	Management (Status)	Plans	# of Members (Contributions; Claims Paid)	Admin Costs	Reserves (Solvency Ratio)	Copay Amount
		Silver (cost as of 2008) • Overall annual limit of P35,470 – designed for young individuals who only need PHC services. Monthly costs for average family based on salary & dependents range from P420 to P550 **Bronze** • Annual limit of P57,200/P68,670 for Single/Family. No HIV benefit. Urban monthly costs for average family based on salary and dependents range from P370 to P1,115 (2008). Rural monthly costs for average family based on salary and dependents range from P333 to P1,008 (2008)				reduced premiums in return for 10% copay on day-to-day benefits
Itekanele						
Individuals – open scheme; work on network basis		**Individual** • Annual coverage limit of P14,400; Monthly cost is P130 **Family** • Annual coverage limit of P22,970; Monthly cost is P230 (1 dependent), P330 (2 dependents) or P430 (3 dependents) – P100 per month for each dependent Fee for service with limit on number of visits per year or per month; provides 20% cash back if no claims	15,000 principles members 45,000 including beneficiaries			No copay but various waiting times
Bothle Medical Plan						
Individuals and corporation	Administered by UNIGEM	**Basic** • Annual overall limit ranging from P14,000 (individual) to P20,000 (5+ dependents); Monthly costs range from P94 (individual) to P296 (5+ dependents) **Classic** • Annual overall limit of P370,000 per year and an option of either 10% or 20% cash back of unclaimed funds after a 3-year period; Monthly costs based on number of dependents range from P293 (individual, 10% back) to P424 (5+ dependents, 10% back) and P351 (individual, 20% back) to P520 (5+ dependents, 20% back) **Executive** • Annual overall limit of P885,000 per year and an option of either 10% or 20% cash back of unclaimed funds after a 3-year period, plus an optional savings investment that matures after 10 years. Monthly individual costs range from P579 (individual, 10% back) to P629 (20% back), plus additional variable costs for dependents and savings contribution	Founded August 2012			10% copay Scheme pays VAT

Eligibility	Management (Status)	Plans	# of Members (Contributions; Claims Paid)	Admin Costs	Reserves (Solvency Ratio)	Copay Amount
Doctors Aid Scheme						
Individuals; work on network basis	Founded by doctors	**Student:** • costs P80 per month; annual limit of P12,625 **Individual** (under 45): • costs P150 per month base, 100 per dependent; annual limit of P18,440 for individual and 37,100 for families **Advanced (over 45)/ Sports:** • costs P350 per month; annual limit of P29,900 for advanced, P29,100 for Sports **Prestige** • costs P495, covers chronic illness including P8,000 annual limit for HIV; P50,000 annual limit **Elite** • costs P595 per month, covers chronic illness including P9,000 annual limit for HIV; P900,000 annual limit **Corporate** • Bronze (costs P300 per month, same benefits as Prestige plan), Silver (costs P495 per month, same benefits as Elite), and Gold (costs P450 per month, includes P10,000 annual limit for HIV and P1,200,000 total annual limit). Fee for service with limits on number of visits per year or per month				No copay
Symphony Health						
Open to individuals, companies, etc.	Board of trustees; administered by Symphonic	**Core** • P200,000 annual limit per family; monthly costs vary based on age from P422 to P756 (individual) plus variable costs for dependents **Classique** • P350,000 annual limit per family; monthly costs vary based on age from P743 to P1,385 (individual) plus variable costs for dependents **Executive** • No annual limit for families; monthly costs vary based on age from P856 to P1,593 (individual) plus variable costs for dependents Must register for HIV and AIDS coverage that covers hospitalization (subject to overall limit for Core/Classique) and ARVs (up to P6,000 per beneficiary for Core, P9,000 for Classique, and P15,000 for Executive). Includes Members Savings Account	Founded Spring 2013			

Eligibility	Management (Status)	Plans	# of Members (Contributions; Claims Paid)	Admin Costs	Reserves (Solvency Ratio)	Copay Amount
Etudiant Medical Scheme						
Individuals; work on network basis		Helps cover cost of care within 9 doctor network. Limits apply to individual visits (i.e. P130 per consultant, P420 per specialist visit, P200 per lab test, etc.). Does not cover HIV and AIDS. Monthly premiums are a percentage of gross salary, based on the number of dependents -- range from 9 percent of Gross Salary (individual) to 13.5 percent (up to 3 dependents)				No copay

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