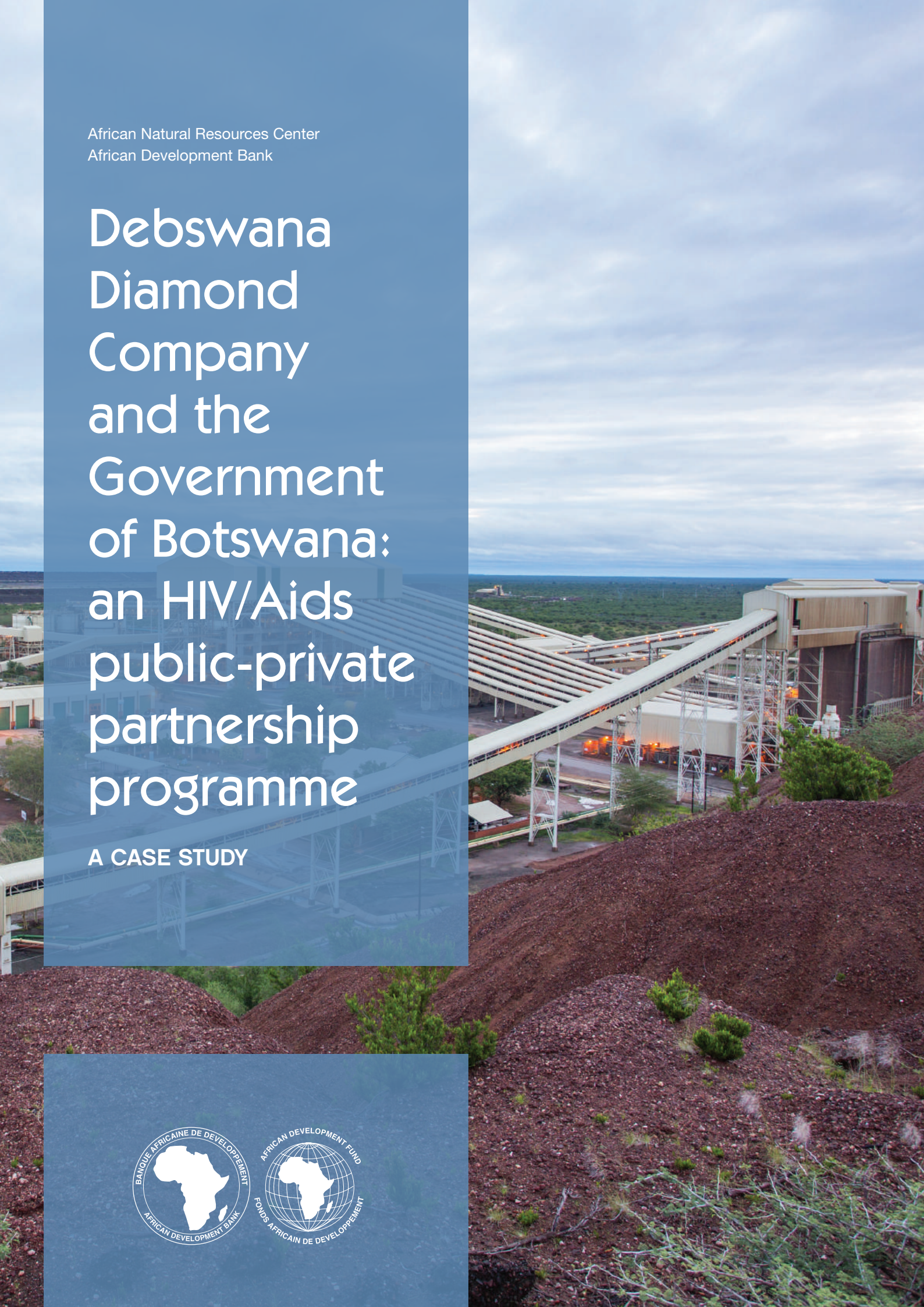
African Natural Resources Center
African Development Bank

Debswana Diamond Company and the Government of Botswana: an HIV/Aids public-private partnership programme

A CASE STUDY



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Preface

The African Development Bank established the African Natural Resources Center as a non-lending entity aimed at building the capacity of member governments in the region to manage natural resources, whether renewable (fishery, forestry, land and water) or non-renewable (minerals, oil and gas). As part of its mandate, the center benchmarks experiences from other regions and supports African governments in performing their custodial obligations by collaborating with regional institutions, the private sector, civil society organizations and donors.

National governments play a central role in developing their countries' natural resources. This role requires a balance of several policy, legal and institutional considerations. It also necessitates a regard for the multiplicity of interests of various stakeholders.

In the extractives sector, protecting inter-generational benefits is a particular challenge given the finite nature of resources. This places an extra burden on policymakers to increase the value gained from extractives development projects while giving investors a fair return.

Overcoming policy challenges is a specific hurdle that extractives resource-rich countries face. There's a particular need to:

- Balance impact on local economies with the impact on national economies.
- Make the correct trade-off between fiscal and non-fiscal benefits derived from the projects.
- Integrate projects into national economies while capitalizing upon the global outreach of multinational corporations' supply chains and related economies of scale to increase project profitability.
- Leverage public-private partnerships to increase human development impact, promote the development of small and medium-sized enterprises, and deliver social welfare services directly to those affected by the extractives projects.
- Secure inter-generational value by investing revenues in productive assets.
- Manage national expenditure and savings to offset the adverse effects of commodity price volatility.

These are but a few of the challenges facing regional governments for which policymakers require practical solutions. To increase development outcomes, governments must make informed choices while meeting public expectations to benefit more from extractives projects.

A particular challenge facing investors and governments is to ensure that the impact of projects is felt as early as possible in the life of extractives projects. Another is to ensure that countries enjoy the benefits despite the time lag between project commissioning, production and payment of taxes. Equally important is the need to stabilise the project environment such that regardless of the project life cycle, commodity market conditions and degree of profitability, projects can still have positive impacts on human development. The answer in part lies in delinking revenue from strategies for achieving human development. This requires development partners to assist governments in developing other alternatives for delivering tangible benefits. The challenge is to generate concrete solutions and knowledge toward achieving such an objective.

An important practical response to bridge the gap is benchmarking experiences of other countries in and outside Africa because, while each response is peculiar to specific national circumstances, the experiences nevertheless offer powerful lessons from which African governments can identify potential policy options and avoid historical pitfalls. These lessons also offer useful policy advocacy tools for the African Natural Resources Center to increase knowledge, foster fact-based dialogue, and capacitate policymakers and CSOs to engage constructively.

ANRC have commissioned a series of case studies to specifically bridge the knowledge gap in the areas of natural resources projects-driven SME development, supply chain-based domestic linkages, extractives revenue management, public-private partnerships and fiscal policy formulation. They are as listed below:

- Anglo American Corporation's Anglo Zimele Small Business Development Initiative in South Africa;
- Chile's Mining Revenue Fiscal Policy Implementation;
- The Nigerian Local Content Board's Policy and Institutional Arrangements;
- Angola's Partnership with Total to Implement National Local Content Policy;
- AngloGold Ashanti Malaria and Public-Private Partnerships in Ghana;
- Botswana's Mineral Revenues, Expenditure and Savings Policy;
- Debswana's Diamond Company and the Government of Botswana's HIV/AIDS Public-Private Partnership Program.

This report, "**Debswana Diamond Company and the Government of Botswana: An HIV/AIDS public-private partnership programme**," illustrates the potential to directly impact on human development outcomes by leveraging the human, financial and managerial resources capacity of mining companies. This study would not have been possible without the contribution and support of a number of partners and experts, namely: Debswana Diamond Company, whose executive management granted ANRC access to its records; Tsetsele Fantan, the consultant who collected the information and documented the findings; and the ANRC team through Thomas Viot, who coordinated the project with Dr. Hudson Mtegha, the report's editor.

Sheila Khama
Director, African Natural Resources Center

The African Development Bank established the African Natural Resources Center as a non-lending entity to build capacity to manage natural resources. The Center's mandate is to assist African countries to maximize development outcomes from the continent's natural resources. The Center advises governments on natural resources management, policy formulation and implementation to enable them to secure greater social and economic value from resource development. The scope of the mandate covers renewable (fishery, forestry, land and water) and non-renewable (minerals, oil and gas) resources.

The Center supports African governments in performing their custodial obligations by collaborating with regional institutions, private sector, civil society organizations and donors. The Center uses benchmarks and best practices from other countries to increase the capacity of governments.

Debswana Diamond Company and the Government of Botswana: an HIV/Aids public-private partnership programme

1. Introduction

The prime concerns of governments and private investors in mineral development may often be at odds. However, a win-win situation requires the fulfilment of common goals. This is only possible through collaboration and an enabling environment where private sector partners can pursue financial gains while meeting host government aspirations.

There are several forms of collaborative arrangements. This study examines one example and illustrates how such a partnership can be leveraged to extract value from natural resources projects. In this case, the Botswana government has entered into a partnership with the De Beers Group, through the Debswana joint venture, in order to improve health service delivery and effectively contain the adverse effects of the HIV/AIDS epidemic.

The report also suggests ways by which such a public-private partnership (PPPs) might be replicated in other countries.

Human capital, technology, infrastructure, access to capital and financing, and the laws that protect investments are vital for countries to attract foreign direct investments competitively. This is an important point of convergence between governments and investors, as well as the foundation for PPPs in the health and education sectors.

Opportunities for PPPs exist across the extractive project life cycle, including the exploration, production and mine closure stages. That said, the greatest potential for the state to extract value is typically during the production and processing phases.

Successful PPPs require role clarity and the allocation of risks between parties, enabling the partners to apportion resources and contribute according to their strengths. One obvious role of governments is to ensure political and economic stability during the life of mining investments. An enabling legislation likewise becomes a key component. Champions - both from the public and private sectors to sustain the relationship - are equally important.

The case of Botswana clearly demonstrates a potential convergence of goals: The country had a shortage of skilled manpower and De Beers and Debswana both made investments in skills training.

3. Health sector in Botswana

At independence in 1966, Botswana was one of the world's poorest countries, with a per capita income between ZAR45 and ZAR50 and an estimated gross domestic product of ZAR25 million.[1] It had a sparsely distributed population of fewer than 400,000 or 2.5 persons per square mile, and an economy based on beef exports and subsistence farming. Road infrastructure was non-existent, with only five miles of tarmac. This made access to medication very difficult (Botswana Government, 1966).

There were a total of seven small hospitals, five of which belonged to missionaries, as well as thirteen health centres, with one registered medical practitioner per 26,000 people and two hospital beds per 1,000 people. of the population and two hospital beds per 1,000 inhabitants. With the economic situation at the time, the government relied heavily on missionaries for the provision of medical facilities and basic specialist services. The more sophisticated specialist services were sought from South Africa and Zimbabwe (then known as Rhodesia).

In 1967, De Beers discovered diamonds in Botswana. With revenues from diamond mining, the government increased the budget for social and economic development and listed health, education and infrastructure development as priorities.

The Ministry of Health is mandated with oversight of private and public delivery of health services. It is responsible for the formulation of policies, regulations, norms, standards and guidelines for health services. It is also a major provider of health services through a wide range of health facilities and management structures.

Healthcare in Botswana is delivered through a decentralised model, with integrated, preventative, curative and promotive primary health care as a pillar of the delivery system.[2] The country has an extensive network of health facilities (hospitals, clinics, health posts and mobile stops) in the 27 health districts. This was not always the case, but it became possible through public expenditure of mining revenues.

The national health policy recognises the need for working closely with other sectors so as to ensure better and sustainable health outcomes. It emphasises the stewardship role of the Ministry of Health (MOH) in ensuring that a package of comprehensive health services are in all health facilities, including those owned by missionary groups, the mines, the private sector and other government organs, taking into account continuity and harmonisation of referral and supervisory functions (Ministry of Health, 2011).

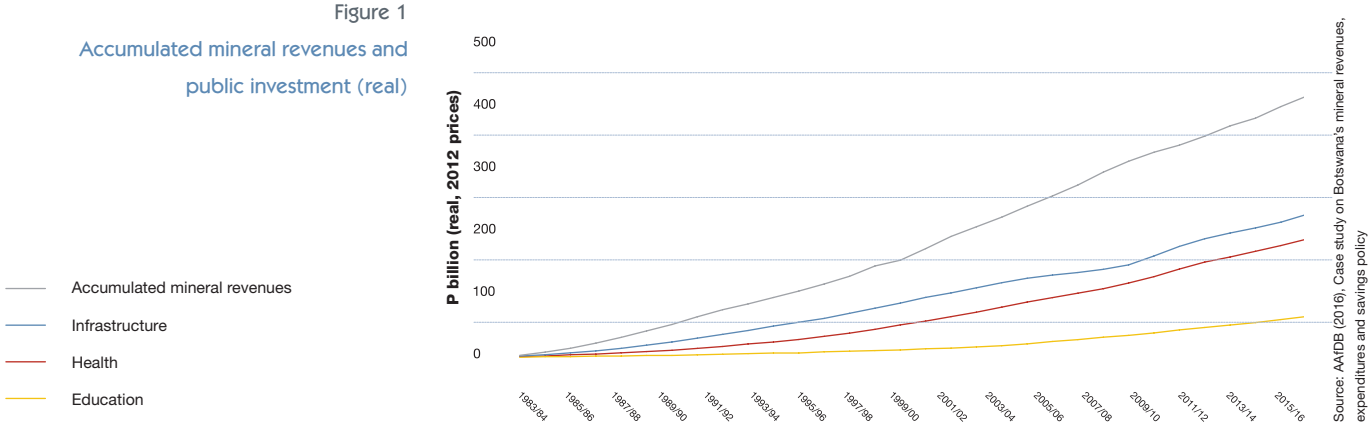
By the early 1980s, the state of the country's health system had greatly improved following the implementation of accelerated social and economic development programs. Figure 1 shows expenditures on social and economic infrastructure over the past three decades.

[1] The pre-independence legal tender was the South African Rand.

[2] WHO defines primary health care as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (World Health Organization, 1978)

Figure 1

Accumulated mineral revenues and public investment (real)



Apart from investing in public health, the Botswana government also forges partnerships with other organisations to increase capacity and leverage third-party resources. It has signed agreements with missionary organisations on the provision of health services and support. The government has also established a negotiating forum on government support for the medical services provided by Christian missions.

In the same vein, the government enters into collaborative agreements with mining companies. Under the agreements, hospitals built and operated by the mining companies to meet employee health needs would be open to the public and serve as referrals for public health clinics where no government hospital has been built. A good example is the BCL copper mine, which is not run by Debswana.

Partnerships alone, though, would be inadequate to meet the challenge. The importance of a genuine business case for the private sector as well as a strong value proposition for the private sector to actively participate in the fight against the epidemic by the state is vital. Also important is the willingness by parties to contribute based on their respective resources. As illustrated below, these principles lie at the heart of the De Beers and government of Botswana partnership in the health sector

4. The HIV/AIDS epidemic in Botswana

In 1985, the first case of AIDS was reported in the copper nickel mining town of Selibe Phikwe. It is estimated that the significant spread of HIV in the country started in the mid-1980s (Botswana National Policy on HIV/AIDS, 1993). At the start of the millennium, Botswana had one of the world's most acute HIV/AIDS epidemics, with a prevalence rate of 38.8 percent among pregnant women and 29 percent among those aged 15-49 (Ministry of Finance and Development Planning, 2003).

The epidemic in Botswana was widespread among both rural and urban populations, making it difficult to manage. A 2000 study by the Botswana Institute of Development Policy Analysis indicated that HIV/AIDS posed a great threat to continued economic growth because of the impact on the labour force, savings and investment.

Leaders of the Botswana government and De Beers, as joint venture partners in Debswana, acknowledged the threat posed by HIV/AIDS on the human capital investment, whether made individually or collectively. The partners had a common vision to protect investment in human capital, reduce business costs and improve employee health, agreeing that HIV/AIDS was a common enemy.

Former President of Botswana Festus Mogae declared HIV/AIDS a national emergency in March 2001. He then created the National AIDS Coordinating Agency, emphasising the need for a multi-sectoral national response to the disease, an effort requiring dedicated and tireless leadership and management.

De Beers boasts an employee-centric philosophy that has transcended generations of leadership within the company. Although the aim of the business is to make profits for its shareholders, the firm should do it "in such a way as to make a real and lasting contribution to the communities in which we operate," according to late chairman of De Beers, Sir Ernest Oppenheimer, as quoted by his great grandson, Jonathan Oppenheimer (AIDS Official Journal of the International AIDS Society, 2007). Jonathan Oppenheimer stated that "businesses are an intrinsic part of society, further that, businesses are therefore right to feel a moral obligation to combat a threat such as HIV/AIDS."

It is these political ideals, intrinsic philosophies and common vision of the partners that influenced the response to the HIV/AIDS epidemic and the subsequent decisions to collaborate in the fight against the disease.

The following is a listing of events in addressing the epidemic:

1987/89

Between 1987 and 1989, Botswana realises the epidemic is rapidly spreading from the national sentinel surveillance and that it is complex.

1995/99

Between 1995 and 1999, Debswana monitors employee absenteeism and death rates and identifies the problem among employees. In 1999, Debswana undertakes the first voluntary anonymous prevalence survey among employees and realizes the magnitude of the problem and its complexity.

1997/02

Between 1997 and 2002, the government of Botswana, through the MOH, makes a decision to involve the private sector in the HIV/AIDS fight.

2001

In 2001, Debswana approaches the government to collaborate on an antiretroviral program, offering its infrastructure and personnel.

2001

In 2001, the government establishes structures in order to effectively manage the national response, providing a clear definition and understanding of the role, function and responsibilities of stakeholders.

The roles and responsibilities for implementing the thematic areas of the revised Second National Strategic Framework (NSF II) 2010-2017 are based on institutional mandates. All stakeholders operate within the ambit of their mandates in creating an enabling environment for the realization of the framework's objectives and outcomes. Specific roles and responsibilities are outlined in the National Operational Plan, which has been developed as a complementing document to the revised NSF II.

5. Public policy and the strategic decision to collaborate

As part of the response to the epidemic in 1993, the government of Botswana adopted a national policy on HIV/AIDS. It mobilised the public, private and non-governmental sectors to collaborate in response to the challenges posed by the disease, clarifying the roles of the different stakeholders and communities.[3] This also gave access to the national leadership to engage on the required intervention (National AIDS Program, 1997-2002).

The government established a national consensus forum to structure the stakeholder engagement process. Through the forum, national leaders consult with stakeholders on a range of policy and operational issues. Based on the principle of "planning with," the government assumed a coordination role and facilitated programming workshops, in line with the National AIDS Coordinating Program.

6. The Debswana strategic partnership

The Debswana Diamond Company is a joint venture that is owned equally by the government of Botswana and the De Beers Group of companies. The parties have equal representation on the board of directors, which gives them an opportunity to contribute to strategic and operational issues so as to in such a way so as to promote their individual and collective interests.

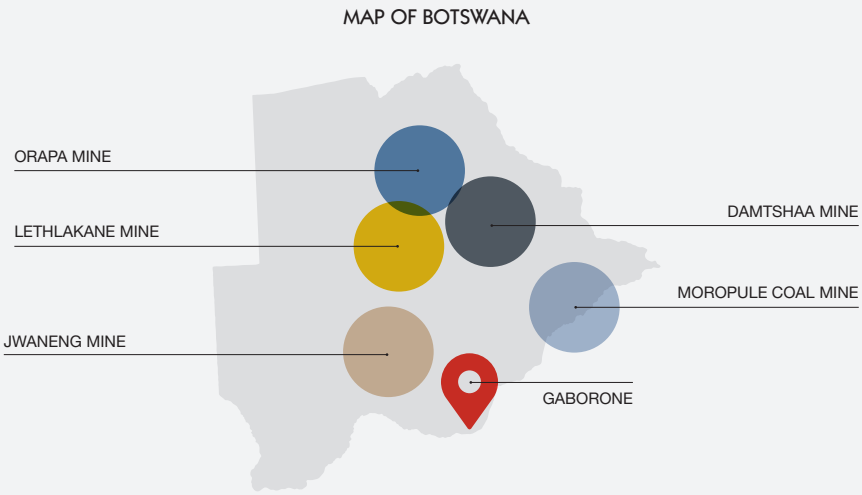
The company mines diamonds at four locations - the Damtshaa, Jwaneng, Letlhakane and Orapa mines (see Figure 2).

At its inception, Debswana established full-fledged communities at the Jwaneng and Orapa diamond mines. These communities have good housing for both married and single employees, shopping and recreational facilities, and primary schools. It built two well-equipped hospitals (with 100 beds each) at the Jwaneng and Orapa mines.

These hospitals serve as referral facilities for government clinics in the areas surrounding the mines (UNAIDS, 2002), and thus increase access to care for those residing in these regions. Beyond its participation in a number of community fora on health and other issues, Debswana is also a member of the health team responsible for the district HIV/AIDS response.

[3] Medium Term Plan II 1997-2002.

Figure 2
Country map showing locations of Debswana mines



Around the time that the Botswana government formulated a policy to tackle HIV/AIDS, the De Beers Group of companies approved a similar policy for its operations worldwide, including those in partnership with the Botswana government. Debswana thus became the world's first company to provide antiretroviral treatment to its employees, their spouses and their children.

Debswana's leadership recognised that the firm could incur massive costs due to the disease, both from employee welfare and commercial perspectives, unless it put necessary interventions in place. By building a hospital at the mine and giving workers free drugs, the company estimates that it has prolonged 125 lives so far. In addition, a high-profile education campaign has led to an overall drop in the level of prevalence amongst company workers, falling from 27 percent in 1999 to 21 percent by 2003 (BenchMarks Foundation, 2009).

Because of Debswana's status as a significant revenue earner for De Beers and the Botswana government, both stakeholders agreed that company operations should not be subject to interruptions due to HIV/AIDS.

Debswana has defined its HIV/AIDS response as a responsibility and a business decision that was necessary to reduce the impact on employees, their families and the company. It has also recognised the need to base prevention interventions locally as communities are much more effective than centralized structures in changing and sustaining the types of behaviours that are required for HIV prevention. The top management at Debswana led the response, with the CEO's office reporting to the board on a regular basis.

Debswana launched HIV/AIDS education and awareness programs for medical personnel in 1988-1989, in response to the first AIDS cases seen at the Jwaneng Mine Hospital in 1987 and at the Orapa Mine Hospital in 1989. The awareness program expanded to the rest of the workforce, as recommended by a small-scale "knowledge attitudes and practises" survey conducted in 1990. The firm appointed full-time AIDS coordinators in

1991-1992 at the Jwaneng and Orapa mines to focus on education and awareness of the rest of its workers, assisted by other structures such as peer educators.

The company's response comprised HIV/AIDS prevention, treatment, care and support. All workers and their dependants received preventive health services sponsored by the company without discrimination. Debswana had two main categories of employees in the mines: employees, or those who had contracts of employment with Debswana; and contractors, who had entered into a contract for service at the mines and are hired through their companies to offer specific services for fixed-term periods.

In 1994, the company took a further step by integrating its HIV effort in its overall health and safety policy, which embraced national and international norms of non-discrimination and no pre-employment testing, emphasized education and information dissemination, and articulated the responsibilities of managers.

Between 1996 and 1999, the company began to experience HIV/AIDS- related morbidity and mortality among its workforce. A significant percentage of ill health retirements over this period (40 percent in 1996 and 75 percent in 1999) were AIDS-related. In 1996, 37.5 percent of deaths were AIDS-related; in 1997, this figure rose to 48.3 percent, and in 1999, to 59.1 percent (UNAIDS, 2002).

Around the same time, Debswana became aware of the potential of antiretroviral drugs to prolong the lives of its employees. In May 1999, the company undertook a survey using the saliva test to determine the prevalence of the disease in the company. Voluntary and anonymous, the survey drew a high level of participation. The results showed that 28.8 percent of the 5,261 employees across all operations were HIV positive, with various operations affected differently.

Following the survey, the company stepped up its interventions and created a full-time senior executive position that would lead the coordination of the HIV/AIDS program and report directly to the managing director. The mandate of this position was "to reduce the impact of HIV/AIDS on the company's financial and human resources and was occupied by the former group human resources manager Mrs. Tsetsele Fantan."

Armed with the mandate, the company's leadership examined various strategic options for responding to the epidemic, including actuarial exercises, stakeholder engagement and an assessment of the extent to which the legal and political environment would be enabling. In 2001, based on the assessments, the company put in place a disease management program, a vehicle through which the company provided employees and their spouses with antiretroviral therapy. Debswana hospitals in Jwaneng and Orapa mainly offered the service.

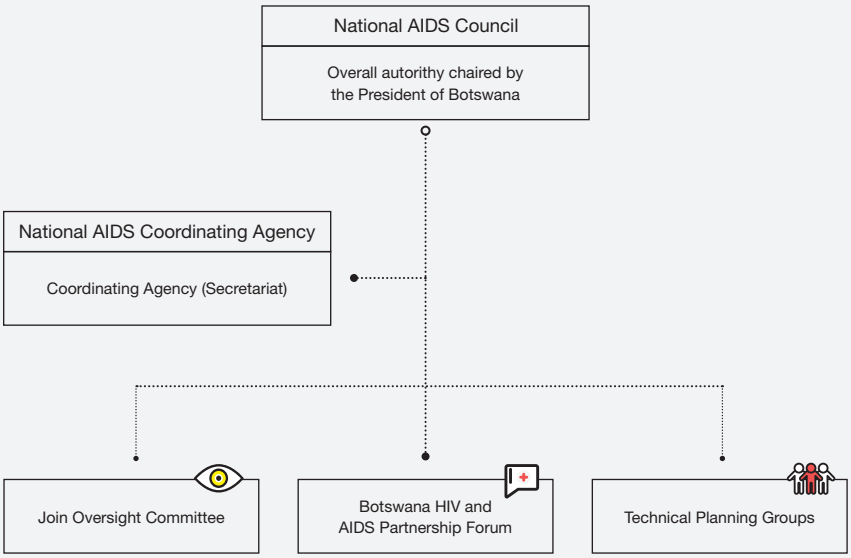
Debswana used the agreed national indicators and targets for reporting the situation in the mines. As the company is a critical economic actor in Botswana, it is crucial for the government to monitor the impact of the epidemic on diamond mines.

7. The collaboration and alignment with the government

Debswana and the Botswana government collaborated to achieve the goals of the national response to HIV/AIDS, providing resources to control the disease, improve access to treatment and monitor the prevalence in mining areas.

To contain the impact of HIV/AIDS, the parties put in place a number of measures. Debswana has representation in the National AIDS Council, a policymaking body chaired by the Botswana president, as well as in the council's technical advisory committees. The company sits on Economic Planning, Health Systems, Clinical Management and Programming and Information Management committees that are advisory to the Council (Muzila, 2015). Figure 3 illustrates the organisational setup.

Figure 3
Organisational chart of institutional arrangements



The functions of the implementation structure's various components are as follows:

7.1. National AIDS Council

The National AIDS Council provides overall authority to the national response. It is the voice that articulates the national priorities that are to be addressed and assures accountability of stakeholders for performance and progress. It provides a high-level forum for policy direction and leadership to the response.

7.2. National AIDS Coordinating Agency

The National AIDS Coordinating Agency serves as secretariat to the National AIDS Council, overseeing the day-to-day management of the national strategic framework implementation. Specific responsibilities include:

- Facilitating the development of the strategic direction for the national response and coordinating program implementation.
- Facilitating the development and implementation of a national HIV/AIDS research agenda.
- Coordinating resource mobilisation, allocation and tracking.
- Coordinating the multi-sectoral joint planning and review processes.

- Facilitating reporting to the National AIDS Council and other stakeholders.
- Coordinating HIV/AIDS knowledge management.

7.3. Joint Oversight Committee

The Joint Oversight Committee oversees the development, implementation and review of the national strategic framework, a national monitoring and evaluation plan, and resource mobilisation and allocation. Specifically, the committee:

- Guides and approves the development of the national strategic framework, National Operational Plan and Monitoring & Evaluation plan.
- Provides oversight on the implementation, monitoring and evaluation, annual planning and reviews of the national response.
- Mobilises and allocates resources for the national response.
- Facilitates national response evaluations and implementation of recommendations.
- Produces national response performance reports and submits them to the National AIDS Council.

7.4. Botswana HIV/AIDS Partnership Forum

The Botswana HIV/AIDS Partnership Forum aims to provide a platform for HIV/AIDS information sharing and to advocate for increased and harmonised support for national response initiatives. Its roles include:

- Providing a platform for national response stakeholders to update members on the progress, achievements and challenges in the implementation of the national strategic framework and make recommendations to address identified gaps.
- Advocating for support to areas where accelerated resources may be required within the framework.
- Identifying policy and programmatic issues emerging from implementation of the framework.
- Promoting documentation and sharing of best practices.

7.5. Technical Planning Groups

The technical working groups develop and provide oversight of the revised national strategic framework's thematic areas to which they are assigned, as well as the associated National Operational Plan and National M&E Plans. The Technical Planning Group roles include:

- Developing the national strategic framework, National Operational Plan and the national M&E plan.
- Facilitating and supporting national or district response integrated annual plans and scheduled reviews or assessments.
- Costing and producing budgets for the National Operational Plan and M&E plan.
- Supporting and monitoring the implementation of the integrated plans and reporting on progress to the Joint Oversight Committee.
- Facilitating the setting of national and district annual plans and targets.

Debswana's contribution

Debswana introduced an antiretroviral treatment program for its employees, their spouses and their children in May 2001, before the government started a similar initiative at Debswana hospitals in Jwaneng and Orapa. It built infectious disease clinics within its hospitals in line with the government model for such facilities to cater for increased numbers of AIDS patients.

The company also identified and tapped a number of private medical doctors at five other locations in the country to register and treat employees and their families who did not live in close proximity to Debswana mine hospitals. These were at Lobatse, to cater for the De Beers prospecting offices; Palapye for Morupule Colliery; Serowe for Teemane Manufacturing; Kasane for Masedi Farms; and Gaborone for the Head office staff.

Debswana moreover employed an adherence councillor at its head office to coordinate the registration of and provide telephone counselling to patients. It collaborated with Aid for AIDS, a South African organisation that provided clinical guidelines, training and monitoring of the Debswana patients.

The company offered the use of its facilities and trained medical staff to enable the rollout of the government's HIV/AIDS program (called Masa in Debswana's hospitals), thus achieving increased access for citizens in the mining communities and catchment areas without infrastructure and manpower costs to the government.

Debswana health facilities, like those of the government, provide integrated health services that include maternal and child health care. The prevention of mother-to-child transmission of HIV is part of the program.

The Botswana government's contribution

The government's Masa program started in February 2002 at the Princess Marina Hospital Gaborone following an agreement between the government and the African Comprehensive HIV/AIDS Partnership, which is a collaboration between the Bill & Melinda Gates Foundation and the drug company Merck. The agreement sought to improve access to comprehensive HIV prevention, care and support; help prevent and treat opportunistic infections; and implement antiretroviral therapy in the public sector (UNAIDS, 2002).

Under the agreement, the government would also launch the Masa program in three other sites, namely Maun in the country's northwest, Francistown in the north, and Serowe in the central district. Each site would cater to its own catchment area; it was expected that about 19,000 patients would be treated by the end of 2002 in all four sites.

Beyond providing antiretroviral drugs, the government offers specialised laboratory services at a Botswana Harvard Partnership laboratory as part of health systems strengthening efforts to deal with the HIV/AIDS epidemic. It also carried out training for all healthcare workers involved in the treatment, care and support of AIDS patients and disseminated publicity materials. It provided guidance through the treatment protocols. "As a government, we recognized the value of collaborating with the private sector, in

particular Debswana, because of their experience and their network of experts, which we deemed as efficient and effective in management compared to government bureaucracy," said Dr Patson Mazonde, formerly of the Ministry of Health.

8. Impact

The Government's leadership in providing direction, setting standards and mobilizing international experts to assist in dealing with the epidemic benefitted both the country and Debswana.

Evidence indicates that antiretroviral therapy reduces HIV transmission and HIV-related morbidity and mortality amongst those living with HIV (UNAIDS 2012). Due to the delivery of free antiretroviral drugs, life expectancy rose to 68 years in 2011 (Central Statistics Office, 2011) from 55 years in 2001.

As of December 2014, there were 34 antiretroviral therapy facilities and 561 satellite clinics across the country dispensing antiretroviral drugs (Ministry of Health, 2014). Data indicate that by the end of December 2014, 63.2 percent of the population or 247,947 people, including those in Debswana catchment areas, were on highly active antiretroviral therapy. Of this number, 3.5 percent (8,578) were children.

Botswana's programme to prevent mother-to-child transmission of HIV is highly regarded as an effective model in the developing world (National AIDS Coordinating Agency, 2010). It is available in all 676 health facilities that provide maternal and child health services, and is thus considered the first programme in Africa to have achieved such a milestone in a span of three years (1999- 2001).

According to the Universal Access Report, Botswana attained a target of less than 5 percent HIV transmission when providing antiretroviral prophylaxis (Government of Botswana, 2008). In 2014, data indicated that the percentage of pregnant women who knew their HIV status at delivery and accessed services increased to 99 percent (MOH, 2014).[4] The National AIDS Coordinating Agency had reported that HIV prevalence is stabilizing although the 2013 prevalence rate of 18.5 percent was slightly higher than the levels in 2008 (17.6 percent) and 2003 (17.1 percent) (National AIDS Coordinating Agency, 2010).

8.1. Life in mining communities

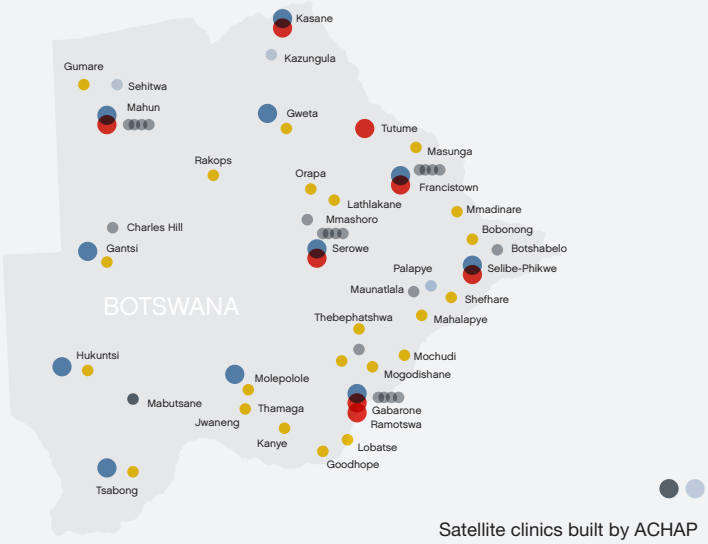
The Jwaneng, Letlhakane and Orapa mining communities are comprised of Debswana employees and extended family members, contractors who provide services to the mines, and residents in the mines' catchment areas who receive medical services from the on-site hospitals for medical conditions. The mine hospitals serve a role similar to district hospitals. While the Debswana employees, spouses and children were already covered by the company's disease management program during workers' retirement years, their extended family members were not.

[4] The National Strategic Framework was initially meant to go until 2016 and was first published in 2010. It has since been updated and extended to 2017.

8.2. Increased access to antiretroviral treatment

Debswana and the government's partnership to roll out the Masa program in mine hospitals served to accelerate the access of mining communities in the catchment areas of operations to antiretroviral treatment at a time when government plans and resources were not adequate. Whithout imposing an additional burden on public facilities, it has enabled mining communities to enjoy such benefits at Debswana facilities earlier than they would have done based on the government rollout plans for Masa. Figure 4 shows the Masa program across the country.

Figure 4
National ARV Program



8.3. Healthier communities

Having early access to antiretroviral drugs meant healthier individuals and families in mining communities. Community members were thus in a position to undertake or continue with other economic activities such as engaging in small business and subsistence farming that keep communities viable. According to anecdotal businesses evidence from Segosha Kono, Debswana's Adherence Counsellor, and Mwamba Nsebula, the Chief Medical Officer, Debswana benefited from the improved productivity of its contractors.

Improvements in health also reduced the numbers of orphans in mining communities and in the country at large from 1990s levels when access to antiretroviral drugs was lacking. People are now able to lead productive lives and and raise their children despite their HIV status as reported by Malebogo Ranko, chairman of the district health management team.

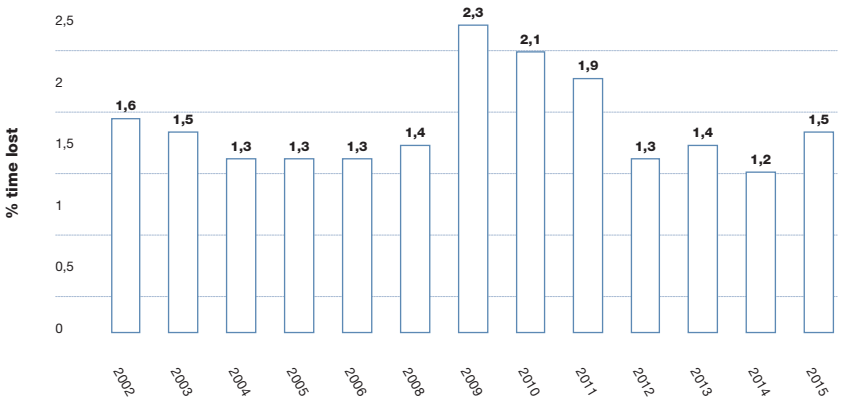
8.4. Reduction of the financial impact on individual households

Had the Botswana government and Debswana not collaborated on HIV/AIDS response, people requiring treatment would have had to travel long distances to get to the four centres covered under the Masa program's immediate rollout. This would have imposed additional financial burdens on households such as the transport and meal expenses. It might also mean loss of wages for daily earners; hence they risk losing their jobs. Other potential costs include lost opportunity for those in search of work and the need to find someone to supervise children in the absence of parents who have gone to seek services for an entire day or more.

8.5. Impact of the HIV/AIDS policy on company productivity

To measure productivity, Debswana traditionally looks at productive time lost due to sickness, morbidity and mortality. Lately, it has undertaken employee engagement surveys that give, among other things, a measure of employee morale. These indicators have been tracked over time and below are a snapshot of the trends from 2002, a year after the company introduced its antiretroviral therapy for its employees and their dependants.

Figure 5
Productive time lost due to illness at all sites, 2002 – 2015



The productive time lost of both employees and contractors from visiting the clinics and time off due to illness was minimized as a result of in-house services. The high rates in 2009 and 2011 were attributed to the increase in sick leave taken, implying that other chronic illnesses were beginning to take their toll on employees. A review of these trends led the company to introduce a new wellness strategy, which aims to prevent chronic non-communicable diseases that had not received the same attention as HIV/AIDS such as hypertension and diabetes.

8.6. Reduced morbidity and mortality

The HIV-related morbidity and mortality at Debswana declined over time as a result of a combination of prevention, treatment, care and support interventions.

Figure 6
Ill health retirements from all operations, 2002 - 2014

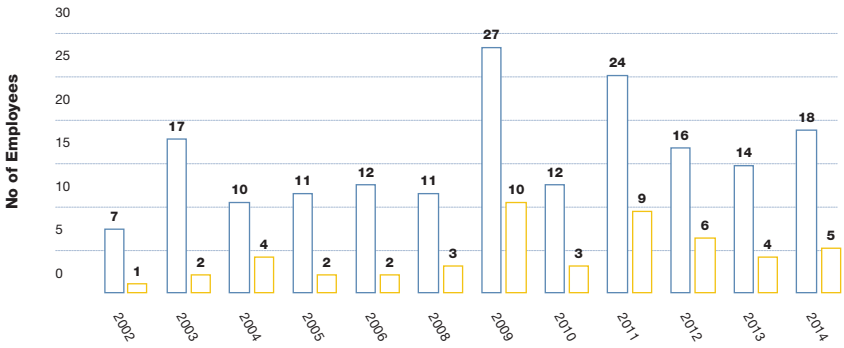
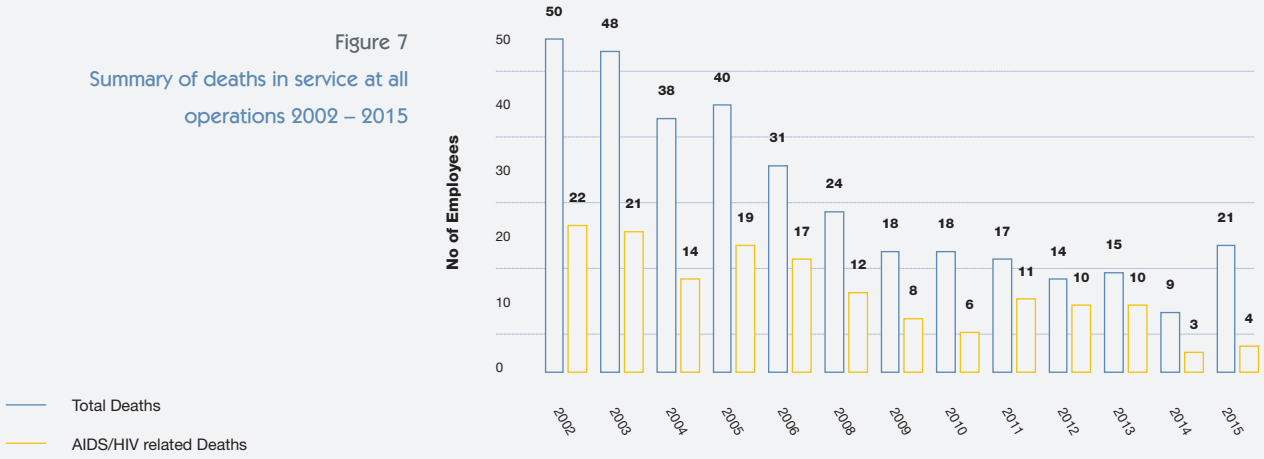


Figure 7
Summary of deaths in service at all operations 2002 – 2015



The reduction in the number of deaths has translated into skills retention over time. As employees and their families gained knowledge about HIV prevention and treatment, they took responsibility to protect themselves against the virus, thus securing the company's investment in human resource development.

8.7. Reduction of financial burden on the company

Shared resources by the parties for the HIV/AIDS program, including infrastructure, manpower, drugs, logistics, training materials and laboratory services, have reduced the financial burden not only on the company but also on the government.

Debswana has established a trust fund to cover the direct costs of its HIV/AIDS program. As the ART Trust Fund currently receives mandatory contributions amounting to 1 percent of the company payroll, the program is considered secure and immune from poor business performance or any organisational change.

8.8. Reduction in HIV incidence

The priority of the National Strategic Framework for HIV/AIDS is to reposition the prevention of new infections as the major focus of the national HIV/AIDS response. Botswana has demonstrated that new HIV infections can be reduced. For instance, new annual HIV infections declined by 71 percent between 2001 and 2011 (UNAIDS, 2012). HIV incidence among the population aged 18 months and above has decreased from 1.45 percent in 2008 to 1.35 percent in 2013, according to the Botswana AIDS Impact Survey (National AIDS Coordinating Agency, 2013). This is the general trend including the mining districts and communities in line with the national HIV/AIDS Response Priorities as set out in the National AIDS Strategic Framework 2010-2017.

9. Lessons learnt

Debswana's response is consistent with the public heath model that comprises prevention, treatment, care and support of both the infected and affected individuals and their dependants as defined in the company HIV/AIDS strategy and policy. There are a number of lessons from this experience.

9.1. Sharing costs between the Botswana government and Debswana

The HIV/AIDS prevention, treatment, care and support programs ran by Debswana for employees and mining communities buttressed health programs in these areas, thus reducing the financial burden on government. It allowed mining communities to have access to related services, hence curtailing the spread of the epidemic.

9.2. The role of consultative forums

The consultative forums informed government strategies to improve program delivery. Through these forums, both government and Debswana shared best practices and knowledge from their international network of partners with experience in research and treatment.

9.3 Shared responsibility

The partnership between the Botswana government and Debswana was based on mutual respect and on recognition of the value that each party brings to the relationship. Contrary to popular belief that nothing good can be derived from working with the public sector because of its inefficiencies and bureaucracy, Debswana said it had benefited a lot from its collaboration with the government, acknowledging that "We need each other and there is no way we could have achieved this success had we not collaborated " (Segosha Kono, 2015).

Debswana employees who were dealing with HIV/AIDS have benefited from the government's Kitso [6] capacity-building program and workshops at district level as well as from updates on the epidemic, including exposure to national and international experts and resources brought by government to support the national program. In monitoring the impact, Debswana was able to obtain guidance from the National AIDS Coordinating Agency on the reporting frameworks and was able to meaningfully compare company statistics with the national and regional statistics provided by Government (B P Mbakile, 2014).

9.4. Debswana's relations with mining communities

According to the chief medical officer at Jwaneng mine Dr Mwamba Nsebula, mining communities prefer HIV/AIDS services offered by the mine hospitals, suggesting their appreciation for Debswana's program. They see these efforts as key to achieving the national vision of a compassionate and caring nation.

9.5. Role of NGOs

As part of its strategy, Debswana worked with local non-governmental organisations to increase awareness of HIV prevention, treatment and care and bring its program to hard-to-reach areas. This support to NGOs enhanced the relationship and trust between the company and the mining communities.

9.6. Lessons for other mining companies

Using its experience, Debswana has supported mining and other private sector organisations to start their own HIV/AIDS programs.

9.7. Private sector financial support

The increasing role played by the private sector in financing and delivering health services in Botswana has led to the expansion of these services. For instance, the merged tuberculosis and HIV program has been rolled out to all 29 of the country's districts, with all health facilities, including those at Debswana mines, providing integrated TB and HIV-related services. This initiative has resulted in 91 percent of TB patients being tested for HIV and receiving their results in 2013 (National AIDS Coordinating Agency, 2010).

[6] The Ministry of Health introduced an HIV/AIDS Education and Training Program to build national capacity for health workers and other people working in HIV/AIDS management. The program was named KITSO, which means knowledge in Setswana

10. The HIV/AIDS programme sustainability

Compared to other large mines globally, the Debswana mines are highly profitable and generate significant revenue for De Beers and the Botswana government. In terms of the Debswana agreement between the government and De Beers, the government receives some 81% of revenue distributions and the De Beers receives the balance. The government's portion of revenue is made up of royalties (10% of gross revenue), corporate taxes and dividends. De Beer's portion is only dividends..

Botswana's mineral revenues have been on a downward trend for at least a decade, falling between 2008/09 from 50 percent to 30 percent of total revenues, and from 25 percent to 10 percent of GDP. Factors include a decline in diamond production, the high cost of investment projects necessary to extend the life of the mines, and the effects of the global financial crisis of 2008-2009.

At the advent of the HIV/AIDS epidemic, the Botswana government received support from development partners to finance its budget. But since the classification of Botswana as a middle-income country around 1992, development partners have significantly reduced their assistance to the country over time.

In 2013, the USAID Health Policy Initiative undertook analysis of the HIV/AIDS program's sustainability given the shrinking funding sources. The analysis indicated that overall, available financing is insufficient due to the rising cost of providing treatment and the inability of the government, despite increasing domestic public spending for the HIV/AIDS response, to close the gap left by the withdrawal of donor support (USAID Health Policy Initiative, September, 2013).

The study identified a number of alternative domestic sources of funding, such as levying cell phone airtime, air travel and alcohol consumption. An alcohol levy has been in place in Botswana since 2008, and the government had collected BWP[7] 1.8 billion, as per the State of the Nation address in November 2015. But there's no evidence yet that the government directs any of the collected levies toward the HIV/AIDS response.

11. Challenges

Both the Botswana government and Debswana have demonstrated political will and commitment in implementing the national response strategy. That said, the effort has encountered several challenges, including:

- Sustaining funding at the national level.
- Juggling competing priorities for resources within the company at the national level.
- Preventing fatigue among implementers, leaders and development partners who see no cure in sight.
- Innovating to address emerging issues and aligning communication messages to the social determinants of the epidemic as indicated by research.
- Sustaining the commitment and momentum among decision-makers and communities to prevent new infections.
- Sustaining behaviour change and adherence to treatment by those enrolled in the treatment programme.

[7] Botswanan Pula

12. Policy considerations for other countries

The HIV/AIDS epidemic has far-reaching social and economic impacts on nations' well-being. As such, it cannot be left to governments to address this problem. It requires the involvement of all sectors of society, including corporations, contrary to the argument by some economists in the 1970s that the only responsibility of business is to make profits.

Profitability and social responsibility are not mutually exclusive. The success of large companies depends in part on the success of the relationships they enjoy with the communities where they operate. Not investing in mutually beneficial relations creates risks that include social strife and political instability.

The perception that the involvement of big business in HIV/AIDS response releases the government from its responsibility to provide its citizens is misguided. Investors complement governments, but the state is accountable for the welfare of its citizens.

13. Lessons for other countries

The collaboration between the Botswana government and Debswana offers important lessons for others to consider.

A supportive policy environment

It is important for governments to create a conducive policy environment guiding investors on how they can get involved in national programs. This lays the foundation for collaboration towards the maximum attainment of desired outcomes. The contribution of companies towards social development, particularly in the communities surrounding their operations, needs to be articulated clearly in policies or through negotiations.

Strong leadership and governance

The importance of a committed leadership is a critical for any partnership. The ability to identify the comparative advantage of private sector partners and willingness to provide an enabling environment for collaboration without subjecting them to the long and tortuous bureaucratic processes is vital to avoid the erosion of the valuable contribution they can make. Apart from its role as the overall custodian of national policy, the government should promote inter-sectoral collaboration and coordination as well as harmonise and clarify the roles and relationships between stakeholders.

Robust health systems and structures

Access to sound health policies, administration systems and structures to support health interventions is another critical success factor. It is especially essential to have a national infrastructure and framework for health PPPs in place before an epidemic.

A multi-sectoral approach

Successful partnerships hinge on stakeholder engagement at policy, operational and community levels. Enabling health care providers, businesses and community-based organizations to participate in the national health program builds trust and allows for the sharing of strategies, information, knowledge, skills and resources between partners.

Through PPPs, governments gain access to corporate management skills and operational efficiencies. It lays the foundation for skills transfer and intellectual property.

Efficient program management

An effective information management system is necessary to assist in the monitoring and evaluation of an HIV/AIDS program, determining the level of success and challenges to ensure continuous improvement. Information sharing between stakeholders will lead to improved reporting of statistics; effective coordination is vital for program sustainability.

Innovation

The HIV/AIDS epidemic is rooted in socio-cultural determinants that make behaviour change a challenge. It is therefore important to be innovative to facilitate the development of new and relevant strategies for preventing and managing the epidemic.

Secure and sustained funding for HIV/AIDS

Curbing the incidence of an incurable disease requires a sustainable financing model and plan. Without sustained funding, other competing development priorities may take precedence over such an effort. For its part, Debswana's board of directors has decided to create a trust fund to continue the gains made from bringing the epidemic under control.

Continued briefing of decision-makers and stakeholders on the epidemic's status helps keep the program focused and ensures sustained reduction of new infections, and maintenance of those receiving treatment.

The partnership between the government of Botswana and Debswana on the HIV/AIDS program is unique, and it presents the business sector and other governments with opportunities to tackle their own health challenges in a creative manner. It should not however be assumed that it can work in every environment. To this end, countries need to consider their own context to ensure the right ingredients are in place to support the type of partnership that would work for them. The principles above could serve as a model for others.

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