Management of the Global Fund Aid programme in Botswana: Challenges and Prospects for health services delivery

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Abstract

This paper examines the institutional management of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in Botswana. We analyse the often contested roles of the state and non-governmental organisations (NGOs) as recipients of GFATM and partners in extending public health service provision to communities. Of importance is that Botswana's first GFATM grant had to be administratively closed, and the country was not awarded any other grant (especially for HIV/AIDS) until over a decade later. Following this, it is of interest to understand the ways in which institutions manage grant programmes. This article concludes that the "big brother" relationship of the state in relation to NGOs is crippling the critical and constructive effects of these organisations to deliver needed community-based health services in Botswana. GFTAM represents a window of opportunity for creating an effective civil society whose local activities will not be seen as being led covertly by the state. This article contributes to both theory and practice within the scholarship of development aid in Africa. Qualitative research methods were used, including in-depth interviews with public sector policy makers, all GFATM principal and sub-recipients, members of the Country Coordinating Mechanism (CCM) and NGOs.

Keywords: Aid effectiveness; Botswana, Global Fund, Management, Principal Recipient. Country Coordinating Mechanism.

Introduction

This article examines the institutional management of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in Botswana's health sector by looking at the role of the State and local NGOs with respect to factors that facilitate or hinder aid effectiveness in health systems strengthening (HSS) with specific emphasis on service delivery. Reference to

HSS in this article refers to activities or strategies aimed at improving six key functions of the health system, namely human resources for health; health finance; health governance; health information; medical products, vaccines, and technologies; and service delivery (USAID, 2015). Emphasis is especially placed on understanding the interactions between the six functions, especially the relationship of actors across the different levels of the system, how they can impact (bring improvement) health outcomes (Chee, et al., 2013). This is essential (broad understanding of HSS) in this article where there is also recognition of the GFATM's view on HSS, which argues that that building resilient and sustainable systems for health is essential to end epidemics and is its strategic pillar.

While HSS can be done at or across different levels of the health system, this article considers the broader socio-political context in which NGOs in Botswana functions, where research on the same remains limited. is looking at This is because its first grant for HIV awarded in 2002 was suspended due to non-performance – it is critical for the country that a repeat on account of non-performance be avoided by especially exploring and finding ways to help strengthen local institutional delivery mechanisms, management and overall governance.

In practice this article helps to understand the ways in which aid recipient institutions operate/respond within everyday politics and practice of power, offering lessons to policy makers, donors and aid recipients' in developing countries on how to develop and maintain effective aid partnerships in healthcare. In addition, some authors have found that countries like Botswana with well-functioning health system and higher income have a lower rate of grant implementation than low-income countries with less-developed health systems.

Methods

The approach in the research was qualitative in nature and in-depth interviews were conducted. The approach provided a platform for participants to share their experience on the GFATM grant in terms of its management overtime. Data were collected between October 2017 and January 2018. Eighteen in-depth interviews were conducted as shown in Table 1. Emphasis was placed on ensuring gender balance.

Table 1: Interviews

Institution	Number of interviews
Ministry of Health and Wellness	3
African Comprehensive HIV/AIDS Partnership	3
Botswana Network on Ethics, Law and HIV/AIDS	1
Botswana Christian AIDS Intervention Programme	2
Botswana Network of AIDS Service Organisations	2
Botswana Red Cross Society	1
Country Coordinating Mechanism	6
TOTAL	18

Formal interviews lasted between 45 minutes and an hour. We interviewed six individuals from principal recipient (PR) organisations — the Ministry of Health and Wellness (MOHW) as state actor and the African Comprehensive HIV/AIDS Partnership (ACHAP). Eight individuals were interviewed from sub-recipient (SR) organisations — The Botswana Network on Ethics, Law and HIV/AIDS; Botswana Christian AIDS Intervention Programme; Botswana Network of AIDS Service Organisations; and the Botswana Red Cross. We also interviewed six members of the Country Coordinating Mechanism (CCM), including government officials who manage the GFATM. In this regard, purposive sampling was used mainly focusing on organisations that either manage or are recipients of GFATM. Given that the institutional recipients of GFATM have had a working relationship over time and are represented in the CCM. The study also used the snowball sampling technique to expedite interview appointments. Secondary sources were also used. These included primary documents produced by the recipient institutions and those prepared by GFATM. This enabled us to access information that would ordinarily be difficult to get in any other way such as people who might not have been willing to talk in a formal research interview or are difficult to track down (Anderson, 2004).

Qualitative data were tape recorded with participants' consent and transcribed verbatim. Most interviews were conducted in Setswana and translated into English, and a few selected for back-translation. Interviews with key informants continued until saturation was reached. Most interviews with government officials were conducted following interviews with other members of CCM. This allowed cross-referencing several issues that were raised by civil

society actors. Furthermore, a fair background record on projects was conducted and provided a basis for data triangulation. Data analysis involved coding and categorising according to themes that emerged. We manually coded the data and categorised it. Developing categories and then counting the frequency of instances when those categories occur enabled us to identify commonalities and differences in the qualitative data, before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes. In conducting this research, all research ethical rules that include ensuring confidentiality, anonymity and informed consent were adhered to. This was done to promote ethical research, and to protect informants. Ethical clearance was obtained (13 December 2017) from the Health Research and Development Division, Ministry of Health and Wellness, Republic of Botswana (reference number: HPDME 13/18/1).

The modus operandi of the GFATM

This article draws on the management of funds provided by GFATM in Botswana where, similar to many other developing countries, financial assistance for HIV/AIDS remains critical. Established in 2002, GFATM has transformed over the years and currently enacts a model that emphasises the critical role to be played by civil society in designing and developing programmes to meet local health needs and priorities. Integral to the model is drawing on country-level mechanisms to implement health aid programmes in recipient countries. Thus, "the fund is led by demand," (Hanefeld, 2014, p 55), uses a bottom-up participatory approach in proposal development and does not seek to be an implementing agency.

In 2018, GFATM reported that its programmes had provided 17.5 million people with antiretroviral therapy, optimised treatment regimens and helped develop models of differentiated care, tailoring services to populations in need and focusing on high-burden geographies (Global Fund, 2018a, p. 12). NGOs are critical actors and state partners, especially for health and health service delivery at the community platform. In low- and middle-income countries these have included profit and non-profit organisations, including local and international NGOs. While the involvement of NGOs in health care is not new, the last two decades have been characterised by a significant proliferation of NGOs mainly due to increased political will and funding support for global health. These NGOs work within a

space and a responsibility which remains the sole responsibility of governments. This means they must work in a way that respects and supports the centrality of country governments.

The GFATM aid institutions are managed by the CCM which comprises PRs and SRs. That means GFATM disburses funds to the PRs. The PRs are responsible for the overall implementation of the grant activities, programme management, financial management, monitoring and reporting. This also includes selection, induction and supervision of SRs which are usually local NGOs, for the implementation of the grant. Kapilashrami and O'Brien (2012) point out that the traditional role of NGOs in addressing the AIDS epidemic was organised around a centralised state that only extended its authority through NGOs in implementing programmes in the communities. The new funding model of GFATM and the emphasis on involvement of CCMs, which has also been the cornerstone of the GFATM architecture, is expected to have a significant impact on the power relations between state authority and the expected authority of civil society under the new model. This is why this article assesses how NGOs (as members and working through CCM) navigate their role within national governments' hegemony as regulators, payers and providers of health care.

Botswana — overview of the case study

The involvement of civil society in Botswana's health sector has been through NGOs without a profit motive. However, the government maintains a strong presence in health service delivery throughout the country. The public health sector also provides comprehensive health services with an absolute coverage across the country provided through an extensive network of health facilities. In terms of coverage the NGO sector presence is limited; most predominantly operate in urban and peri-urban areas. Two-thirds of Botswana's population is urban based.

As such, the involvement of NGOs in health service delivery in Botswana is generally not viewed as replacing government in addressing public health challenges, but largely as enablers for local access and accountability to especially extend a government mandate and to overcome slow and bureaucratic government processes. This is also because most civil society organisations operate only in urban and peri-urban areas, with very few in rural areas. Given the extensive network of public health facilities including mobile stops, health posts, clinics and hospitals across the country's health districts it is never the case that in a particular area there only are NGOs to meet people's health needs. There is therefore an

entrenched paternalistic relationship between local NGOs and the state that needs to be recognised within the broader debates of the instrumentality of NGOs (civil society) in the successful implementation of the GFATM grants in the country.

As an upper middle income country, Botswana would otherwise not qualify for funds from GFATM. However, Botswana remains one of the countries most affected by HIV in the world and thus qualifies for funds. With a small population of just a little over 2 million (Statistics Botswana, 2011), Botswana continues to battle with the devastating health and socio-economic effects of HIV/AIDS. Similar to other developing countries, Botswana's response to the HIV/AIDS epidemic has been an emergency vertical disease control programme. Although supported by various development partners the response has been administered by the Ministry of Health, with an HIV/AIDS department and also working with the National AIDS Coordinating Agency (NACA) which also led/managed the GFATM grant.

The first GFATM funding to Botswana was in 2003/04. At the time, the Ministry of Finance and Development Planning (MFDP) was PR. The award (Round 2 of the Global Fund) was planned to support Botswana's strategic fight against HIV/AIDS which (then) focused on a multi-sectoral approach to address the various challenges brought on by the epidemic, at a total of US$18 580 414. The award to MFDP specifically focused on "Scaling up multi-sectoral response to HIV/AIDS". MOHW and the Ministry of Local Government, Land and Housing (MOLGH) were the two main channels (SRs) for this grant. Specifically, MOHW received funds geared towards antiretroviral drugs and the prevention of mother-to-child transmission of HIV/AIDS programmes, while MOLGH received funds targeted for home-based and orphan care programmes. This grant was administratively closed due to non-performance just a year into the two years of the grant period.

According to the *Sunday Standard* newspaper in 2009 (Letswamotse, 2017), Botswana's proposal for funding was rejected on grounds that the submitted proposal lacked a clear description on how its strategies would be implemented. In 2016, almost a decade later, Botswana received its second funding from GFATM (Round 13) to the tune of US$27 043 807 for HIV/AIDS and TB — marking "a new phase of partnership" between the two parties (Global Fund, 2018b). The various institutions responsible for programme conceptualisation, implementation and evaluation have been critiqued to various extents in different writings, and by the interviewees in this article. These are discussed in detail.

Similar to the management of GFATM in other countries, the Botswana CCM was established in 2002 and represents a key element of the GFATM implementing mechanism. The CCM currently consist of 26 members drawn from three sectors defined by GFATM, which include government, civil society, and multilateral and bilateral institutions. Each of the three sectors meets and follows a transparent process to nominate and appoint a representative by submitting their nominations to the CCM Secretariat. The CCM in Botswana is led by a CCM secretariat under NACA. For government, nominations are based on positions of seniority (senior level management) at director level and above in the ministry/agency. Multilateral and bilateral constituencies nominate representatives according to their own structures and nominations are expected from organisations supporting programmes on HIV/AIDS, TB or malaria as well as health system strengthening. Civil society, however, includes all non-government constituencies such as academic, NGOs, community-based organisations, people living with HIV, key populations, gender organisations, youth organisations, the media, private sector, people with disability and faith-based organisations. Sectors are expected to provide documentation detailing the process of nomination undertaken. Examples of documents providing sufficient evidence of the election process for members from non-government constituencies include: (i) minutes of constituency election meetings; (ii) membership lists from organisations participating in the election process with evidence of coverage; (iii) letter from organisations participating in the election process explaining the process and criteria with signatures of members of the organisations that were present at the meeting; or (iv) the document (or the relevant parts of election process) in which election of members is explained to have occurred.

Findings and discussion

In view of the second award of the GFATM grant for HIV/AIDS programmes, and the potential for further funding, debate has ensued around the effectiveness of institutions implementing GFATM programmes in Botswana. Findings of this study conclude that this debate has centred around the appointment of the CCM and PR; the PR performance and engagement with SR; GFATM management through the CCM; representation and improving access to health services for certain key population groups; monitoring and evaluation; and other programmatic issues.

Performance of the CCM

Although there are some respondents who are confident that all members of the CCM are able to make meaningful contributions during meetings, or even hold members and PRs accountable, key concerns about the performance of the CCM included the view that:

> *Technically a lot of them are not clued on with regards the three diseases, it really shows when we are debating issues. You find that the debate is always skewed towards government partners who work on these. The CCM capacity gap is glaring, I am not sure we have the right people … (SR and CCM member).*

Another respondent also raised the following concern:

> *I don't think our CCM is very effective, because I see a number of high level officers not attending, we have a lot of people attending there who will not be able to make decisions so it's like things are not taken very seriously. A lot of times we would be discussing the same things with no improvement or accountability at all (SR and CCM member).*

These extract reveals to us how in some ways the effectiveness and accountability of the CCM is questioned. That some members have a knowledge gap on technical areas of the grant management points to weaknesses in the participatory capacity of all. As such, it is necessary to promote an understanding across all actors that each actors' value to the mechanism must be recognized for what it is. For example, members of civil society and NGOs are generally recognized as key actors in HSS because of their relationship and in depth knowledge of their communities and issues that affect them. This is their primary contribution, and their performance in the CCM must be judged through this lens – that while they may not speak to the technical aspects on the grant, they are the voice and eyes of their communities.

Participation in the CCM

Respondents pointed out that a lot of positions within CCM are given to State stewards thereby making the state play a dominant role. In this regard, the government is viewed as only interested in representation rather than the effectiveness of that representation in the CCM. This problem is exacerbated by staff mobility within the public sector which poses a challenge as new people keep coming in and out of the CCM, thereby slowing down

processes. However, the problem of dominance may sometimes extant to a limited number and type of NGOs seating in the CCM. Kapilashrami and McPake (2012) argue that participatory mechanisms in the CCMs seem to have been characterised by dominance by the more established recipients (NGOs) in the decision-making processes. For Kapilashrami and O'Brien (2012), in situations where civil societies and other stakeholders engage with each other, centers of power are reproduced and often influenced by numerous factors including control of resources and network identities which sometimes lead to other local voices being silenced. While there was indication that the CCM processes followed have ensured a fair representation across all constituencies, participation in the CCM proceedings eventually came down to the individual representative and the primary interest of their home organization – whether it is making contribution from the lens of people living with HIV, people with disability or an advocacy group. These dynamics contrast with state actors view which aims to be all encompassing but viewed by others as lacking the in-depth appreciation of issues that matter to certain groups.

Concerns were also raised regarding the capacity of state actors appointed to sit in the CCM. One responded stated:

> *I am not sure if we have the right people representing their Ministry or Department, it would work if it was senior staff, such as Permanent Secretary level. Officers with decision-making power. But they nominate lower staff who then have to refer for decision-making, that is limiting participation and progress (CCM Member).*

Other respondents actually argued that it is the Permanent Secretary who makes decisions. Yet the permanent secretary rarely, if ever, attends CCM meetings. Despite the fact that there *is* a limitation of how many times you can miss the meetings.

In this regard decision-making processes are often delayed. Other respondents also felt that some members (especially government officials) of the CCM do not take the mechanism seriously. In one of the observed meetings of the CCM, one of the CCM members commenting on a presentation made by State PR indicated levels of frustration and concern. He indicated that the way the State PR was presenting their expenditure rate was incorrect, as it also did not tally with what was captured on the dashboard. He echoed that when public officers seem not to take the issues raised by the CCM seriously, especially as State PR it not only tarnishes their image as responsible officers but also casts doubt on the role of the CCM as a mechanism for accountability and oversight.

Respondents also indicated that the CCM did not hold PRs to account; some stated::

> *Really if we were to be honest, in terms of being able to appreciate issues and take people to account, the PR and everybody, it's like people are very nice on each other. When someone has not performed the CCM normally they wouldn't like to scream at a person that you haven't done well, I think it is that attitude that draws us back (CCM member).*

There also remains a question of whether the level of accountability and stewardship required of the CCM is realistic given the power imbalance. The State (Officers) weld a lot of power within the CCM which emanates from its monetary and regulatory power and also power that is conferred to them by civil society members (of the CCM) who from time to time are powerless on a number of fronts, including technical knowledge and the offices they represent as members of the CCM.

An issue arose around the GFATM grant sustainability as well, which means that if the grants cease most local NGOs will generally look to government for funding and would wish to become the "preferred" partner in extending government authority and services to communities. Thus at any given point participating NGOs representatives want to build and maintain positive relationships/networks with state actors with very little antagonism at any given interaction. In fact, in Botswana, most funding for HIV/AIDS programming comes from the government. For example, 89%, 80% and 79% of fund spent in 2003, 2004 and 2005 respectively were from state coffers. The share contributed by external sources gradually increased over the period; 10%, 19% and 20% (UNAIDS, 2007).

Overall, many respondents argued that the CCM perhaps does not appreciate the magnitude of the responsibility given to them in managing the grant. In particular recognising that when the country fails to perform optimally with the grant it is really the CCM that has failed.

However, the role and value of the CCM is generally acknowledged by all as integral to the success of the country's performance with the grant. While the bypassing of coordinating mechanisms that have existed under aid for HIV funding is not new (Spicer, et al., 2010). There remains need to improve its capacity, especially to build its technical representation among civil society members to promote greater participation even as a core principle of the GFATM.

In order to improve the oversight of implementation role of the CCM the complex interlinkages between their various activities must be recognised and deliberate efforts

instituted to address them. There is an inherent dynamic complexity in the CCM due to its composition. At any given point, different members of the CCM are positioned to play key roles including as technical lead on an area of priority, as lead of an influential NGO or as lead of a state enterprise. When these varied elements among members are viewed positively, they provide a useful dynamic partnership that can be channeled in ways that do not undermine any one member of the mechanism.

Similar to what other studies have found, CCM members are sometimes ineffective at representing their constituencies and in executing their mandate through the mechanism (Brugha et al., 2004; Kapilashrami & McPake, 2013). This capacity element goes beyond the technical limitation that CCM may demonstrate across technical issues that may need to be addressed, but mainly speaks to the various obstacles that impede the mechanism providing/representing local participation — the inclusiveness and partnership for which the fund has received credit for (Hanefeld, Hale, & Hale, 2011). Capacity building to improve the effectiveness of the CCM needs to recognise the plurality and dynamic power relations that play out in everyday practices and identity-based networks and organisational interests.

Conflict of interest in the CCM

One of the key principles of governance for the GFATM is the institutionalisation of clear and transparent processes also able to promote country ownership. The CCM in Botswana found itself in a case where many local NGOs raised concern around issues of transparency and unfair treatment bordering around potential issues of conflict of interest. Following the awarding of the current grant and the appointment of PRs and SRs, it emerged that nearly all the NGOs that were selected as SRs were also members of the CCM. This means that they were also part of the team that wrote the concept note for Botswana's proposal application.

However, some respondents felt that the bidding process was transparent and open to everyone. A respondent noted;

> *... competition was fair, so anyone regardless of whether or not you were involved you just had to apply and you had to compete. I think everyone was given a fair chance. I know someone might say others already knew the content, but I think ample time was given to everyone to research (SR and CCM Member).*

In addition, at each meeting, members of the CCM are required to fill a form where if necessary they declare their conflict on any particular issue under debate. This is consistently

done and the CCM Secretariat keeps documentation of the same. However, it was observed in one CCM meeting that some members were not very clear what the conflict of interest was about and whether they did have one or not. Overall and with communication perceived to be generally good and enabling the governing role of the CCM, respondents generally felt conflict of interest is well managed and always addressed as needed, as stated by one respondent:

> *There are guidelines for the meetings, if there is a section that I feel am conflicted on, I have to note in the conflict of interest form that during this section I will recuse myself ... and other members do that as well. We have had sessions where we have had to leave the room even as representatives of government. So we really try to apply the rules and guidelines.*

However, the challenge here is whether within the CCM there can be discipline and punishment to ensure that issues are followed as prescribed. But who ensures discipline and resolves conflicts emanating from and within the CCM?

To ensure that conflict of interest does not affect the effectiveness of the CCM, various approaches have been suggested and effected, including instances where members have recused themselves during each CCM meeting. Elsewhere it has been suggested that PRs should not vote in the CCM but only act as ex officio members where they only provided their technical reports to the CCM (Kapilashrami & McPake, 2013).

Representation of constituencies

Aiming to boost country and partners' capacity to provide essential commodities and strengthen service delivery to prevent and treat HIV and AIDS, tuberculosis (TB) and malaria the GFATM has been instrumental in reaching key populations. This especially worth noting for Botswana, where programming for certain key populations such as lesbians, gays and transgendered people remains a challenge in Botswana. The GFATM has thus enabled focused programming to meet the needs of key populations in ways that would otherwise have not been possible under the current policy constraints or lack therefore. However, the composition of the CCM seems to pose challenges that affect issues of accountability and even oversight. As already indicated by some of the respondents, many spaces on the CCM are given to government people, including in the executive committee. This has been seen as a great limitation in that overall the government PR – the Ministry of Health and Wellness

(MOHW), is not performing very well compared with ACHAP. Respondents noted that in nearly every meeting, their reporting was flawed but they would still come to yet another meeting with similar errors even when recommendations have been made to help them improve the standard of their reporting. It has also been difficult to call the MOHW to account. Other studies have also found that in countries where the grant implementation was ineffective, government dominance in country CCM was evidenced (Brugha, et al., 2004). This tension does have a negative impact on GFATM program implementation.

Given that there are no strict rules to help facilitate fair representation especially through various constituencies, the element of participation and representation is challenged by state dominance. NGOs are almost reduced to viewing themselves only as extending the State authority as opposed to powerful partners with some level of autonomy. This is exacerbated by the fact that in the country, the state continues to exercise its authority as a funder for other projects that most of the local NGOs are implementing.

Capacitating local NGOs who also become members of the CCM, in ways that can also shift power centers may promote effective representation and participation by all constituencies. Also, what remain core to improving representation and implementation is the need to promote optimal public accountability to help ensure goals are not diverted and those given stewardship are held accountable for all their actions.

Appointment of principal recipients

A PR is a country-based agency or organisation that is financially and legally responsible for programme results. PRs for the GFATM grant are nominated by CCM members and approved by the fund following independent assessments by the appointed local fund agents. These agents report directly to the GFATM. The ability of PRs to implement programmes depends on their organisational capacity and their ability to work with the CCM and other relevant stakeholders to ensure that proposed services are delivered and reach agreed national targets.

Botswana had two PRs for the current grant ending December 2018 and central to this article — MOHW as state actor and ACHAP. ACHAP is a “hybrid organisation” registered as a limited liability company in Botswana, which also has a US 501(c) 3 registration.

This research established that the appointment of MOHW as PR in Bostwana is mainly viewed by most respondents as the state’s continued tradition of control over donor funds and

a persisting perception that non-state actors cannot be trusted with donor funds. This view is perhaps reinforced by the establishment of the Development Partners Coordination Forum under MFDP.

Non-state actors argue that the establishment of the Development Partners Coordination Forum by the State is also a power issue, where State stewards are seen as wanting to retain control over non-state actors (especially local NGOs). In this regard, a respondent opined that if Government was serious about building meaningful partnerships with local civil society organization and or NGOs they would be deliberate about it. Currently there is general perception that "government does not want a strong civil society or NGOs". Respondents also argued that in Botswana, NGOs are the least respected and government does not really value their input.

However, according to MFDP Officials, the Development Partners Coordination Forum has played a significant role in monitoring the quality of aid in the country – providing for example a database that enables the country to track the trend of external funding. Commenting on these views, an Official from the MOHW stated*: "a lot of times what we call NGOs, a lot of them are one man shows – and that gives room for corruption or flouting of governance processes and systems"*. Hence the state has an obligation to monitor NGOs.

Other NGO respondents concurred with this pointing out that most civil society organisations are born out of need by people who have a passion for social justice and often not necessarily qualified to manage projects and programs. A respondent stated that:

> *Your passion can take over and then you lose that element, there are times when there are no boundaries or accountability or you have 'founder syndrome' that prevents you from being a part of a structure that governs properly (SR and CCM member).*

Hence emerging organisations are often viewed as 'new' and inexperienced. Therefore, monitoring does not mean they do not value the NGOs. One state official emphasized this by making reference to the effect that the current (under review) National Strategic Framework III stipulates that in order to revitalise primary health care at least 30 percent of services will be delivered through community health structures. This will mean specifically engaging/partnering with local NGOs. The official stated:

The role of local NGOs is well recognised, the problem in the past has always been capacity. We have seen many of them submitting sub-standard proposals. Government wishes that NGOs could manage the funds, but … in the end accountability lies with Government (State Official and CCM Member)

Another state official, posited that, given the capacity problem,

it will be a tragedy when the money is given just like that to NGOs. So there is still that element of monitoring – because the PR also must be on his toes, there must be M & E people, there must be programs people who are helping all these SR (State Official, ex CCM member)

However, respondents among the NGO community posited that it is actually the government's PR role that has affected performance of the GFATM programming in the country. Poor performance on the part of government has been attributed to government's tradition of bureaucratic processes which results in procurement bottlenecks that delay implementation and therefore reporting on grant expenditure. Various respondents who noted that echoed this view:

At one point, the CCM wrote to the State PR raising concern about the delays in procurement processes that were also affecting implementation. Government has numerous bureaucratic processes that create bottlenecks, and the CCM has to find ways of putting pressure through relevant offices to address the challenges (CCM Secretariat)

Other respondents also pointed to other critical processes within government that are not easy to fast-track, including recruitment and appointment to senior positions which can take up to a year. For example, when the position of Global Fund Manager with the government PR was approved, the government recruitment processes took a year (CCM member). In general, commenting on the capacity of MOHW, a respondent observed that:

We have seen the biggest absorptive capacity challenges within the government. People often make a mistake to think that you only talk about absorptive capacity challenges within civil society – there is no capacity within government, and its worse … if you look at the Ministry of Health who is one of the leading PRs – if you look at the units which

a leading within the Ministry today, almost 3 Directors are acting and they have been acting for the last 3 years – you know what is means when you acting and decision-making … (CCM Member).

Other implementation barriers reported by respondents included the state departments' attitude towards the procurement and reporting system and procedures and the GFATM and its alignment to the government systems. As such, poor performance that ends up being reported for government PR sometimes is not because services were not provided but mainly because there was no proper documentation, , including incomplete records or incomplete process. For instance, extended period can pass between the issuance of a government purchase order, service delivery, submission of an invoice and disbursement of funds for payment to a vendor/supplier.
Respondents emphasised the need for the government to respond to these challenges because in the end the country has to show acceptable levels of programming success and expenditure rates. The CCM Secretariat also stated that whenever needed it would make a case especially to MFDP which assists/facilitates large government procurements to give priority to Global Fund funded programmes. But this can only be achieved by responsible officers completing their part in this process by facilitating tender process for MFDP to act on their submission — and often this is where the challenge lies.

With respect to the second PR, the ACHAP, the majority of non state actors respondents showed concern around its legitimacy as a local NGO, as well as its commitment towards building local NGOs capacity in the area of HIV and AIDS programming. Respondents highlighted that while ACHAP is located in Botswana it remains unclear whether it can be viewed as an indigenous/local NGOs or even an entity with vested interest to capacitate and grow local NGOs. One respondent highlighted this and pointed out that while ACHAP had over 90 local NGOs expressing interest to be SR to deliver services in their Districts and within areas of their technical expertise, only 4 SRs were appointed. "It doesn't mean the other (NGOs) were worse off – just have more SRs and build them". This is especially so given that "*even the NGOs that were selected were at 40% pass – they were just better in terms of personnel at the office and with internal audits etc*."

However, comparing MOHW and ACHAP as PRs, it is generally observed that ACHAP is performing much better in terms of implementation. Almost two-thirds into the grant period the MOHW's performance was rated at around 34% compared to about 70% for ACHAP.

Respondents who are state officials and also members of the CCM had an explanation for this. Unlike in other GFATM recipient countries, Botswana is allowed to use government votes (funds) and receive reimbursement from GFATM. This means that it often happens that an expense for a GFATM funded programme can occur but because the process of reimbursement has not been completed the dashboard will reflect low burn rate/expenditure. This was also observed in one of the CCM meetings where in their report, state actors appeared to be reporting a higher expenditure than what was reflecting on their dashboard and other members of the CCM felt the report was incorrect.

Besides government bureaucratic processes that mainly delay procurement and access to other government funds in lieu of GFATM money, respondents were of the view that to improve government's absorptive capacity, GFATM grant should be integrated into government fiscal plan in a manner that shows state burn-rate as government purchase orders are issued – which will normally reflect a commuted amount/expenditure. Furthermore, it was suggested that appointing a Grants' Manager at NACA/MOHW as well as MFDP could assist in addressing challenges that the state PR experience.

Promoting health-financing awareness among State actors and the cushion provided by the GFATM grants to the country may also assist in mind-set change. Targeted efforts aimed at engaging all stakeholders in meaningful dialogue on the management and use of GFATM resources to address domestic funding gaps in the country are needed. The focus for these engagements should be aimed at how available domestic and additional external funds can be allocated more efficiently, including filling in gaps on costed and agreed upon national strategic priorities for HIV/AIDS and must be understood in the broader context of supporting national health financing systems.

The capacity of the state as PR reflects some of the long-standing challenges around implementation and performance overall. With some of the most suited policy frameworks, Botswana has struggled over the years with poor implementation (Kaboyakgosi & Marata, 2013). Thus, other studies have pointed out that Botswana's implementation challenges go far beyond issues of bureaucratic processes that slow implementation. Kaboyakgosi & Marata (2013, p. 316) have raised concern that implementation challenges are often due to: "… declining public accountability, lack of commitment to reforming the public sector and a decline in commitment by state authorities." It is therefore necessary to ensure that in determining the role of the state as PR, attention should be given to the requisite skills and

aptitude of state actors for their role and scope in implementing programmes funded through the Global Fund.

Programmatic issues – alignment and harmonisation

Respondents raised concerns around programmatic issues — alignment and harmonisation. Respondents indicated that there is a lot of duplication between players and fighting for turf which also affects quality as people have become creative and learnt how to manipulate the numbers. One respondent questioned whether entities appointed as PRs should also be involved in implementation, arguing that:

> *It really gets complicated when you have to compete with your mother (the PR). Roles also get very confusing. Sometimes country data gets complicated because same people can access similar services from different providers (CSO representative and CCM Member).*

More efforts are needed to strengthen the role of umbrella organisations such as the Botswana Network of AIDS Services Organisation (BONASO) to promote a concerted endeavor among NGOs and reduce fights for turfs and duplication of efforts.

GFATM and the appointed PRs need to rethink the fundamental aspects of collaboration, participation and consensus building. Collaborative approaches built on key principles/strategies such as building alliances around a common mission/vision, around shared resources to meet identified community needs can be areas on which organisations are capacitated on.

Performance based funding

Performance-based funding, which is a fundamental principle of the GFATM model, provides a platform for grant recipients to demonstrate that they can convert grant financing into results. It is a key element among CCM members in Botswana and is seen at every phase of the grant life cycle, from initial country application development to grant negotiation and signing to regular oversight of implementation and disbursement decision-making through to the renewal of the grant. Probably not wishing to suffer a similar fate of the 2003/04 grant, there is a general commitment and sense of urgency among all PR actors to ensure good performance overall. Interviewed respondents agreed that performance of

various actors providing services through GFATM assistance are aligned to country priority needs with regards to HIV/AIDS and TB as well as providing services to intended beneficiaries – judged from the quarterly reporting.

However, the challenge remains with Government PR where the CCM is not able to reallocate the allocated resources to more effective PR or programs:

> *The challenge happens most times for the CCM with government PR, how do you get rid of your government ... your entire system in the country is based on the MOHW. So in these cases the best thing is who can meet, who can we talk to. It is important that you have critical people at the right levels to put pressure when needed (CS representative and CCM Member)*

There is general frustration with government PR because respondents feel they are slow and not moving the money. It is almost as if CCM members in reviewing the PRs reports at their quarterly meeting are only interested in the level of the funds burn rate. It was not surprising that in one of the meetings a representative of the development partners and CCM member cautioned members to ensure that their pre-occupation with burn rate (expenditure against budget) does not overlook issues of quality in service delivery. Highlighting that while scaling up health programs to reach more people and offer more services is a necessary step toward achieving epidemic control of HIV and ending AIDS, the quality of services provided is equally important.

The quality of services affects the outcomes and eventually the impact of health programs, poor quality health services — services not delivered according to recognised standards — will have suboptimal or even adverse effects on the health of the population covered. In addition to the risk to health, poor service quality can undermine the effective and efficient use of the available resources for HSS. Concerns around data quality were also indicated and members reminded that issues of quality are some of the integral components of performance based funding.

Respondents in the meeting acknowledged this limitation, indicating that the various reports they receive prior to CCM meetings do not provide a lens through which they could assess quality. There is need to build capacity among CCM to help them understand key measurement and indicators associated with every funded projects.

Monitoring and evaluation

Weaknesses were generally raised with regards to both monitoring and evaluation (M&E), more specifically in terms of technical capacity and issues around programming. In terms of monitoring, routinely collected data are often not analysed to inform programme management, especially at local programme management levels. Another key challenge reported was the timeliness with which data and necessary reports are provided from the districts.

Furthermore, sometimes data used for M & E is not provided in a manner that it can provide evidence in terms of coverage indicators that are disaggregated by key populations for instance. Further, it was reported that some programs do not consistently plan or conduct evaluative activities. Lack of financial and programmatic management capacity were linked to delays in program implementation. Some PRs, for instance, complained that SRs lacked capacity to collect and report financial data but also generally had financial management gaps, where one SR lamented that “financial people will make or break it”. Data quality assurance mechanisms were also reported to be lacking especially among some of the SRs, who also had to be capacitated to help them improve their reporting.

The data quality framework developed by the GFATM to guide the assessment of data quality defines data quality as fitness of data for grant management, analysis, evaluations and external reporting. Thus programmatic, financial and procurement data used at all phases of the grant management process should be accurate, timely and complete. Poor data quality is a huge reputational risk to the GFATM business model as it can lead to inappropriate disbursement decisions as well as inadequate program management and an inability to demonstrate accurate results, especially at country level.

PRs are able to use funds aimed at capacity building to strengthen locally implementing partners on areas where they are found to be lacking such as M&E. Periodic reviews have been conducted for SRs under ACHAP where these are also provided with regular training/updates based on collaboratively identified gaps. Evidently, various capacity building efforts in these have characterised almost all of the interactions between PRs and their SRs.

Nonetheless, one major challenge that remains is the internal brain drain among/across organisations, where people who are trained in M&E and other programme technical issues

leave. To address this challenges, organisations need to invest in knowledge management to help reduce the effects of this brain drain.

Conclusion

his article revealed the institutional management processes of the GFATM grant in Botswana. The government collaborates with NGOs, especially through CCM and PRs — the cornerstone of the GFATM architecture. However, there is a general perception that government does not perform well as PR, is slow in making decisions and also controls most decisions and therefore is likely to give the country a bad rating under the performance-based funding aspect of the GFATM model. Unlike in other countries that receive GFATM funding, it appears the CCM model has not yet fully transformed the power dynamics between the state and civil society in Botswana. This article concludes that the "big brother" relationship of the state over NGOs is crippling the critical and constructive effects of these organisations to deliver needed community-based health services in Botswana. This may perhaps be attributed to the country's long-standing approach to policy making or governance which some have termed "paternalistic developmentalism". There is a critical need for GFATM programming in Botswana to improve the CCM capacity and to reduce government decision-making dominance in order to promote accountability and good governance for better health outcomes in HIV/AIDS health care service delivery.

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References

Anderson, R. (2004). Thematic Content Analysis (TCA) 1 Descriptive Presentation of Qualitative Data, http://rosemarieanderson.com/wp-content/uploads/2014/08/ThematicContentAnalysis.pdf

Bearce, H. D. & Tirone, C. D. (2010). Foreign Aid effectiveness and the strategic goals of donor governments. *The Journal of Politics,* 72(3), 837-851.

Statistics Botswana. (2013). Botswana Population Census 2011. Government Printers, Gaborone.

Brugha, R. et al., (2004). The Global Fund: managing great expectations. *The Lancet,* 364(9428), 3-9.

Chandar, A.2007. Aid Effectiveness and Growth in the Developing World: Does Institutional Quality Matter? (MA Thesis), Williams College Williamstown, Massachusetts. https://web.williams.edu/Economics/Honors/2007/Chandar_thesis.pdf (Accessed May 12, 2018)

Dalgaard, C.-J. & Hansen, H., (2017). The return of foreign aid. *The Journal of Development Studies,* 53(7), 998-1018.

Doucouliagos, H. & Paldam, M., 2009. Conditional aid effectiveness: A meta-study. *Journal of International Development,* 22(4), 391-410.

Deborah, A; Brautigam and Knack, S. (2004) Foreign Aid, Institutions, and Governance in Sub-Saharan Africa, Economic Development and Cultural Change, Vol. 52, (2): 255-285

Elayah, M., 2016. Lack of foreign aid effectiveness in developing countries: between a hammer and an anvil. *Contemporary Arab Affairs,* 9(1), 82-99.

Goodhand J and Sedra, M .(2006). Bargains for Peace? Aid Conditionalities and Reconstruction in Afghanistan. Netherlands Institute of International Relations, https://www.clingendael.nl/sites/default/files/20060800_cru_goodhand_sedra.pdf (Accessed January, 10, 2018).

Gulrajani, N., 2011. Transcending the great foreign aid debate: managerialism, radicalism and the search for aid effectiveness. *Third World Quartely,* 32(2), 199-216.

Hanefeld, J., Hale, T. & Hale, D., 2011. *The global fund to fight AIDS TB and malaria. Handbook of innovations in transnational governance.* Cambridge: Polity Press.

Kaboyakgosi, G. & Marata, K.P., 2013, 'An analysis of Botswana's implementation challenges', PULA: Botswana Journal of African Studies 27(2), 309–324

Kapilashrami, A. & McPake, B., 2013. Transforming governance or reinforcing hierarchies and competition: examining the public and hidden transcripts of the Global Fund and HIV in India. *Health Policy and Planning,* 28(6), 626-635.

Kapilashrami, A and O'Brien, O (2012a) The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit?, Global Public Health, 7 (5), 437-451

Letswamotse, P., 2017. *Global Fund threatens to switch off Botswana's HIV/AIDS life support.* Gaborone: Sunday Standard Newspaper.

Moyo, D., 2010. *Dead aid: why aid makes things worse and how there is another way for Africa.* New York: Farrar, Straus and Giroux.

Moyo, D. (2009) Dead Aid: Why aid is not working and how there is another way for Africa. London: Allen Lane.

Omotola, J. S. & Saliu, H. (2009). Foreign aid, debt relief and Africa's development: problems and prospects. *South African Journal of International Affairs,* 16(1), 87-102.

Quibria, M. (2014). Aid effectiveness: research, policy and unresolved issues. *Development Studies Research,* 1(1), 75-87.

Sachs, J. (2009). *Aid ironies.* Huffington Post, May 24.

Spicer, N., J. Aleshkina, R. Biesma, R. Brugha, C. Caceres, B. Chilundo, K. Chkhatarashvili, A. Harmer, P. Miege, G. Murzalieva, P. Ndubani, N. Rukhadze, T. Semigina, A. Walsh, G. Walt, and X. Zhang. (2010). National and subnational HIV/AIDS coordination: Are global health initiatives closing the gap between intent and practice? *Global Health* 6:3, 1-17.

StatsBotswana. (2011). Botswana national population census 2011. http://statsbots.org.bw/sites/default/files/publications/Population%20and%20Housing%20Census%202011%20%20Dissemination%20seminar%20report.pdf (Accessed April, 6, 2018)

Sumner, A. & Glennie, J. (2015). Growth, poverty and development assistance: When does foreign Aid work?. *Global Policy,* 6(3), 201-211.

The Global Fund. 2018. Botswana Overview. https://www.theglobalfund.org/en/portfolio/country/?loc=BWA&k=2d777324-7b1f-48ad-a1e0-72f6e4d2b646 (Accessed July, 8. 2018)

The Global Fund.2008. The Global Fund Implementer Series. 2008. Country Coordinating Mechanisms Principal Recipient and Sub-Recipient Selection Processes. https://www.theglobalfund.org/media/5477/ccm_2008thematicprsrselection_report_en.pdf?u=636488964620000000 (Accessed , September, 19, 2018).

The Global Fund. 2018. The Global Fund Results Report 2018. https://www.theglobalfund.org/media/7741/corporate_2018resultsreport_report_en.pdf (Accessed September, 20. 2018)

UNCTAD, (2011) Enhancing aid effectiveness: From Paris to Busan, http://unctad.org/en/Docs/tdbex53d3_en.pdf (Accessed, February, 4, 2018).

USAID.2015. USAID's vision for health systems strengthening. https://www.usaid.gov/sites/default/files/documents/1864/HSS-Vision.pdf (Accessed September, 12. 2018).