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Public-Private Partnerships in the Fight Against HIV/AIDS: A Case Study of Botswana

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PUBLIC-PRIVATE PARTNERSHIPS IN THE FIGHT AGAINST HIV/AIDS
A CASE STUDY OF BOTSWANA

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Since the late 1990s, public-private partnerships in the health care field have increasingly been applied. Driven by a common goal, actors from the public, private, and third sector work together in partnerships. This paper will analyze an initiative that is aimed at providing nationwide access to HIV/AIDS treatment in Botswana. Very prominent members of the private and third sector, namely the Bill and Melinda Gates Foundation and Merck, Inc./Merck Company Foundation, are supporting the partnership. Botswana was chosen as the pilot country because its President, Festus Mogae, demonstrated outspoken leadership in the fight against AIDS. AIDS has had devastating effects, especially for sub-Saharan Africa, where 68 percent of all worldwide infected live. The virus has destroyed families and economies; it orphaned 15.2 million children worldwide, among them 12 million in sub-Saharan Africa, and led many to believe that a national strategy to combat the disease is not feasible (UNICEF, n.d.). Despite the criticism, the African Comprehensive HIV/AIDS Partnership (ACHAP) was launched in 2000 and has been extended until 2009. The program has tremendous resources, yet it took some time to get off the ground. As of late 2006, 72.2 percent of all Botswanese eligible for treatment are receiving the life-prolonging medication, which is provided by Merck at no cost. The partnership continues to grow and expand its role model character in the worldwide fight against HIV/AIDS.

INTRODUCTION

Public-private partnerships (PPPs) are a combined effort of actors from the public, private, and third sector. They come together in various formations to fulfill a common goal. This paper analyzes a PPP in the health-care field. The African Comprehensive HIV/AIDS Partnership (ACHAP) is a collaboration of the Bill & Melinda Gates Foundation, the pharmaceutical company Merck & Co., Inc./Merck Company Foundation, and the Government of Botswana. These actors have come together "to support Botswana's national comprehensive HIV/AIDS strategy to prevent new HIV infections and to reduce the morbidity and mortality of HIV/AIDS" (ACHAP, 2007). This mission highlights the common goal that all parties involved in this partnership try to achieve—to reduce the impact of HIV/AIDS in Botswana.

As individual entities, these actors would not be able to function in such a comprehensive way with regard to the goals of the partnership because key elements, such as access to drugs, funding, cultural understanding and expertise would be lacking. Every actor brings a certain skill set into this collaboration and only together can the mission be tackled.

The literature on public-private partnerships is thorough. While sometimes also called Privately Financed Projects (PFPs) or Private Finance Initiative (PFI) (eg. Hejne, 2007), the idea of collaboration between actors from various sectors remains a central feature. PPPs in the health care sector have also been covered by various authors (eg. Barr, 2007; Suchman, Botelho & Hinton-Walker, 1998; Velho & de Souza, 2007). However, most literature focuses on interventions in one country and on one disease. Comparative country studies are rare and not necessarily applicable to the topic of HIV/AIDS. However, there have been intermediate assessments of ACHAP, though none in the past few years, which discuss this new type of approach towards tackling the disease (Clark & O'Brien, 2003; Ramiah & Reich, 2005).

The impact of HIV/AIDS has been widely covered (e.g. Green, 2003; Itano, 2007; Kalipeni, Craddock, Oppong & Ghosh, 2004; Van Niekerk & Kopelman, 2005). Though the pandemic is affecting people worldwide, African countries are the hardest hit. Hunter (2004) even compares the disease and its impact on the African economy, society, and future to the plague that ravaged Europe and the world in the 14th century. As will be seen in the case of Botswana, the disease startled development efforts and has an impact on all levels of society.

The example of ACHAP was chosen for this paper because it demonstrates a large-scale philanthropic effort. The Gates Foundation, as one of the most affluent foundations worldwide, and Merck, a company that holds patents on life-saving medications, have found a way to work together to find a systematic approach towards what the United Nations General Assembly has called "an unprecedented human catastrophe" (UN General Assembly, 2006, p.1). Botswana displayed strong political leadership since its independence in 1966, yet faces one of the highest HIV prevalence rates. The government of Botswana, the Bill and Melinda Gates Foundation and Merck, Inc./Merck Company Foundation decided to combine their efforts to create a role model approach in fighting HIV and AIDS.

Definition of a Public-Private Partnership

The term public-private-partnership is being used in various contexts. Each partnership is defined in a different way to account for the specifics of that partnership. A comprehensive definition is given by the European Investment Bank (EIB). It states that:

> The term PPP covers a wide range of situations […]. [T]he key feature of a PPP is that it involves a risk sharing relationship between public and private promoters, based on a shared commitment to achieve a desired public policy outcome. In this sense, 'Public-Private Partnership' is a generic term for the relationships formed between the private sector and public bodies often with the aim of introducing private sector resources and/or expertise in order to help provide and deliver public sector assets and services. The term PPP is, thus, used to describe a wide variety of working arrangements from loose, informal and strategic partnerships to design build finance and operate (DBFO) type service contracts and formal joint venture companies. (EIB, 2004, p. 2)

Angerer and Hammerschmid (2005) note that the concept of a PPP "promises a synthesis of the efficiency of the private sector with the involvement of civil society […]. [These] partnership ideas fit well into current discourses of a network society […] and 'public governance' implying a fundamental change in the role of government from provider to enabler and increasing erosion of traditional sector barriers" (p. 131).

Angerer also refers to Ham and Koppenjan who note that "[t]he development of successful PPPs is seen as 'one of the most important challenges facing organizations in the public and private domain in the first decade of the new millennium'" (Ham & Koppenjan, 2002, p. 594 as cited in Angerer & Hammerschmid, 2005, p. 130).

While PPPs are being utilized in various environments, this paper is concerned with their implementation in the field of health care. As Barr (2007) demonstrates, the term "PPP" gained increasing significance; now public-private partnerships in the health care field are increasingly common as a mean to approach worldwide health care concerns. Gardner et. al. (2008) state that the number of partnerships and initiatives has been growing since the late 1990s, and as Barr (2007) notes, "…initially most were focused on specific diseases such as HIV/AIDS, tuberculosis, and malaria. Recently there has been enthusiasm for using public-private-partnerships to improve the delivery of health and welfare services. …especially in developing countries" (p. 19).

Despite the lack of evidence that a partnership in the health care sector is more desirable than traditional approaches, the concept is being promoted by the World Health Organization (WHO) and other UN entities concerned with health-related issues (e.g. United Nations Development Program, n.d.). Hsiao (1994) noted that the privatization of health care systems is an "illusory magic pill […]. Neither pure centrally planned nor free market health systems can achieve maximum efficiency "(p. 356), suggesting that a partnership that combines actors from the public and private sector could be a viable alternative.

Barr (2007) noted three reasons for the growing involvement of public-private partnerships in the health-care field starting in the late 1990s. Firstly, a purely private sector approach was met with skepticism from all sides. The question of motives and underlying goals is often imminent with companies engaging in corporate social responsibility. Secondly, the U.S. federal government increasingly collaborated with private universities and pharmaceutical companies in order to develop and market new pharmaceuticals. A third reason can be seen in the commitment of the Bill and Melinda Gates Foundation, the Rockefeller Foundation, and others, to "rely extensively on the public-private partnership model when funding efforts to address the growing worldwide crises of HIV/AIDS, malaria, tuberculosis, and other major diseases" (ibid., p. 20-21). Hence, collaboration seems to be the only way to confront the immense health care challenges, faced especially in developing countries.

The Impact of HIV/AIDS in Sub-Saharan Africa

The human immunodeficiency virus (HIV) continues to ravage the already most severely affected region of sub-Saharan Africa. Despite a decline in new infections to 1.7 million in 2007, still 68 percent of infected people worldwide, or 22.5 million, live in sub-Saharan Africa (WHO, 2007).

These numbers, however, do not reflect the impact the virus has on society. Out of fear of being ostracized from the community, the sick are often too afraid to see a doctor. As a result, many first see a doctor when their disease has already progressed so far that the process of rehabilitation will be a long and strenuous one. These patients require more assistance and medical attention in a system that is already strained.

HIV and AIDS (acquired immune deficiency syndrome) carry stigma of a bad lifestyle and fear, which make it difficult for the infected to come forward with their disease. They do not change their lifestyle; the lack of adequate care in turn leads to a faster disease progression and endangers others. Botswana passed a voluntary testing policy that tests everyone seeking medical attention unless they chose to decline the testing. This has reduced stigma and opened up society to discuss the disease.

AIDS also has a dramatic impact on children who are often orphaned by the disease. Their despondency, however, starts sooner. When a parent gets sick, the responsibility of generating income for the family is partially conferred to the children. They take care of their parents, cook, and run errands. This cycle leads to less access to food and general care, and often the children also drop out of school. Once the parent has died, the children are facing the decision of living with relatives or heading their own household. However, due to the immense impact of HIV/AIDS, many relatives are reluctant or unable to take care for even more kin. For a detailed analysis of this cycle of dependency, see Arnab & Serumaga-Zake (2006). Orphans often stay with grandparents, who are too old to take care of additional grandchildren, or with distant relatives, who in return of having the children stay with them, demand a contribution to the household. Usually, this means that the child has to work for the relative and cannot or only irregularly attend school.

Less education and less opportunity to learn life skills from their parents limit the abilities of these children to be economical achievers. They perform low-skilled labor and are "destitute and vulnerable [. As a result] they are tempted to perform any type of work, even if it is unconstitutional to do so" (ibid., p. 233). As an immediate result, the lower literacy rate and a low to non-skilled workforce are also affecting a country's development efforts and it will take years to regain what was lost due to HIV/AIDS.

Numerous actors, be it countries, international aid agencies, the United Nations, grass root organizations, or the private sector, are attempting to fight this disease and its devastating impact. Every initiative is different and requires different commitments from the parties involved. While many African countries have adapted national HIV/AIDS strategies, the efforts within the country are divided among the many actors and a comprehensive and joint effort is hardly ever seen. As pushed by the UN, Botswana as well as other countries has adopted a national HIV/AIDS strategy in which programs supported by ACHAP take leading roles (Republic of Botswana, 2004).

The Creation of ACHAP – a PPP to fight HIV/AIDS

As previously noted, PPPs bring together actors from various sectors. In order to fight HIV and AIDS in Botswana, the Botswanan government, the Bill & Melinda Gates Foundation as well as Merck & Co. Inc/Merck Company Foundation came together to found the intermediary ACHAP (African Comprehensive HIV/AIDS Partnership). This joint effort by actors from the public, private, and civil society sector aims at working together in order to raise Botswana's institutional capacity and to fight HIV/AIDS in the country.

Since its independence in 1966, Botswana has been able to grow from one of the poorest countries to a per capita GDP of over U.S.$11,000 in 2004 (Central Intelligence Agency, 2008). This growth can be attributed to strong political leadership as well as economic strength found in diamond mining and a growing significance of tourism. However, this development is in danger as HIV/AIDS has spread in the country.

A recent assessment of the Joint United Nations Program on HIV/AIDS (UNAIDS) shows that the per capita GDP has declined from over U.S.$11,000 to U.S.$8,920 (UNAIDS, n.d.). This can be directly linked to the HIV/AIDS prevalence in the country. As noted above, HIV/AIDS impacts a country's economic abilities. The disease weakens the individual to the point where family members need to step in to take care of the sick, hence, two incomes are lost and a downward spiral into poverty begins. Also, a higher HIV prevalence means a lower life expectancy and less school education as children are forced to drop out of school due to inability of the parents to pay school fees, the need to take care of sick family members, or the lack of teachers who have also fallen ill.

The life expectancy in Botswana has dropped from 65 years in 1990-1995 to 50 years (CIA, 2008) and even to 40 years (UNAIDS, n.d.) in current estimates. Despite the variation, the data point to a significant decline in life expectancy over a short period of time. At a significantly high level, the HIV/AIDS prevalence was 37 percent in 2003 (CIA, 2008) but has declined to 23 percent to 32 percent in 2006 (ibid; ACHAP, 2006). This decline might be attributed to the ACHAP initiative and its approach not only to provide the sick with needed anti-retroviral treatment, but to also invest in education as a preventative measure.

Who are the actors?

ACHAP was initiated in July 2000, when Merck and the Gates Foundation founded the collaboration and joined forces with Botswana's President Festus Mogae. Already in 1999, Merck and the Gates Foundation had discussed possible means of collaboration in the fight against AIDS. Botswana was chosen as project country because of its strong democratic political leadership that was not afraid to look the disease in the eye. Also, the country did have a certain infrastructure in place, such as a health care system, which meant that the initiative would be able to utilize and built upon an existing level of knowledge and infrastructure (Bill & Melinda Gates Foundation, 2006). As President of Botswana, Festus Mogae has been outspoken on behalf of those suffering from AIDS. It has been this bold leadership that attracted the attention of the Gates and Merck foundations.

The created intermediary ACHAP is a joint leadership effort to work with the government of Botswana and its entities. While the contributions of the actors may vary, each is required to conduce to the agreement. The Gates Foundation and the Merck Company Foundation each committed U.S.$50 million over a five-year period in order to "strengthen its health infrastructure, such as training new health workers and managers, and establishing new laboratories and mobile clinics" (ibid., p. 3). Merck also committed to distributing free supplies of two of its antiretroviral (ARV) drugs (Crixivan [Indinavir sulfate] and Stocrin [Efavirenz]). The Government of Botswana, in turn, in addition to collaborating with ACHAP was expected to buy non-donated ARVs from other pharmaceutical companies to cover the expected need.

Motivation

Any party engaging in a public-private partnership does so because of a certain motivation. Vian, Richards, McCoy, Connelly, and Feeley (2007) note that "companies can use philanthropy as a way to rebuild eroding trust and establish the public acceptance needed to stabilize their marketplace" (p. 8).

The Gates foundation is being guided by two core values: "All lives—no matter where they are being lived—have equal value" and "To whom much is given, much is expected" (Bill and Melinda Gates Foundation, 2008). These values explain the Gates commitment to fighting HIV/AIDS in such a large-scale effort because they demonstrate that the Gates foundation is aware of their financial powers and what could potentially be achieved by it. The fact that all lives are to be treated as equal supports the notion that people living with HIV/AIDS (PLWHA) should not be subject to ostracism.

It has been contested that resources for HIV patients should rather go towards people who are not infected yet. However, if every life is to be regarded as equally valuable, then the question of whether or not terminally ill people are being supported by a high profile initiative becomes obsolete.

The motivation of Merck is not as straightforward. Clark & O'Brien (2003) note that there is no law that forces corporations to pursue philanthropic efforts, but they question if there is a moral obligation to providing their potentially life-saving drugs to developing countries in a more accessible manner. In the case of Merck, it can rightfully be stated that the company has "recognized that [it has] duties beyond earning profits and following the letter of the law" (ibid., p. 35).

Merck had several options to contribute its pharmaceutical expertise. It could have loosened its patent on the needed medication so that generic manufacturers would have been able to produce the drugs at a lower cost. Also, Merck could have reduced its costs on the ARVs, yet the company chose to donate the drugs to be administered through ACHAP. By choosing this option, Merck retained the patent and does not risk being accused of making a direct profit from this collaboration by forcing the Botswanan government to buy Merck drugs. In fact, through collaboration with ACHAP, the government of Botswana has the right and duty to purchase any other necessary drugs from pharmaceutical companies other than Merck.

The government of Botswana has responsibility for the welfare of its 1.7 million people. As a democratically elected entity, the government has to be concerned with developments within the country. AIDS has had a devastating effect on the nation's economy, level of development, and society at large. When approached about a possible collaboration, the government understood that taking part in a pilot program is not a guarantee for success. However, it had nothing to lose, as it did not have the resources to implement a countrywide strategy to combat HIV/AIDS on its own.

Goals and Strategy

The African Comprehensive HIV/AIDS Partnership has four main goals, as identified by Clark and O'Brien (2003). These are:

1. reduce HIV-infection and transmission;
2. improve accessibility to comprehensive HIV care and support across a continuum from home to hospital;
3. improve access to prophylaxis and treatment of opportunistic infections and to HAART in the public sector for all people living with HIV/AIDS, who are eligible for treatment according to nationally established guidelines;
4. strengthen sustainable improvements of health care systems and mitigate the impact of the epidemic (p. 31).

As one of the first steps, a pro bono study was conducted by McKinsey in order to assess if a national ARV program would be feasible. Upon this strategy, the first year goal of providing 19,000 patients with access to antiretrovirals was set (Bill and Melinda Gates Foundation, 2006, p. 4).

The government of Botswana also negotiated with McKinsey to prepare a plan of implementation. However, these negotiations failed when President Mogae was pressured to start implementing the program (Ramiah & Reich, p. 547). After initial setbacks, the program was able to enroll almost 40,000 people out of an estimated 260,000 HIV positive adults in the ARV program by the end of 2004. The number of hospitals that provided free access to the drugs was raised to 31, which also contributed to an increase in people who benefit from the program (Bill and Melinda Gates Foundation, 2006, p.4). Today, about 1,000 people per month enroll in the free ARV distribution program. The rise in administering hospitals is due to the provision of ready-built containers that could easily be moved and installed as hospitals in the provinces. This guarantees access and has helped to reach remote areas within the country (Ramiah & Reich. 2005).

This high rate is also due to a policy change, which asked for a voluntary HIV test every time someone would seek the help of a doctor. Though people have the option not to take the test, only a few declined it. With an acceptance rate of 89 percent, the test plays a significant role in combating HIV in Botswana. Only if people and doctors know about the status can they start fighting the disease. The fact that everyone is subject to the test reduces the stigma associated with going to a testing center and being seen there.

While everyone infected with the virus is eligible for treatment, only those with CD4 counts of less than 200 are receiving treatment, meaning free ARVs, if available.[1] The medication helps boost their immune system to bring them back to a CD4 count that is normal for an HIV-infected person (around 500) (Cichoki, 2007).

What Problems Did the Partnership Face?

Leadership

The managing directors of ACHAP have changed as the program faced challenges. After being led by Donald de Korte, who is a physician and led a Merck company subsidiary in South Africa, it became apparent that the initial focus was too much centered on HIV/AIDS being a clinical issue. Tsesele Fantan, who has experience in leading the AIDS response team in the DeBeers-Botswana government partnership, took over from de Korte, and Executive Director Themba Moeti now heads the partnership. Luke Nkinsi, who has extensive experience as a doctor specializing in tropical medicine, is the Chairman of the Board of Directors and represents the Gates Foundation. The initial boost of management expertise was needed in order to get the program off the ground. While medical expertise is essential in running the program and making decisions, management skills are needed to distinguish the needs and wants in the partnership and for PLWHA.

Hierarchy

Besides the need for strong leadership, the partnership had to face power struggles among the three partners. The assets of Gates Foundation make it a strong partner. While the government of Botswana welcomed the efficiency the private sector could provide, it "felt that its wealthy partners overstepped their boundaries" (Snibbe, 2006, p. 13). In several instances, it became apparent that the affluent partners used their leverage to influence the decision making

[1] The CD4 count refers to the amount of T-helper cells in the blood. T-helper cells are supporting the immune system. A healthy human has about 1,000 CD4 cells in a pea-sized amount of blood. The HI-virus attacks the T-helper cells and eventually lowers the blood count. If the blood count is above 200, the person is considered HIV-positive. If the count falls below 200 the person is considered to have AIDS.

process (ibid.). This did not contribute to the process of building mutual trust but rather inhibited further collaboration. However, "ACHAP learned to accommodate the Botswanan government's culture of consultation and consensus building" (ibid., p. 14) and is now better able to facilitate the decision making process.

Bureaucracy

ACHAP and its programs are closely tied in with the Ministry of Health. This close collaboration has enabled the good relationship necessary to fight a national enemy. However, "every new hire, new acquisition of equipment and new policy initiative" (Clark & O'Brien, 2003, p. 33) needs to be approved by the Ministry. This causes delays and frustrations on the side of ACHAP, which cannot move and act as fast and flexible as it intends to.

Capacity

The demand for treatment and the treatment model were problems early on in the partnership. After six months into the program, the numbers of enrolled patients already exceeded the number of treated patients. While improvements have been made, the gap continues (Ramiah & Reich, 2005). The reason for this gap in treatment is mainly the lack of health care providers. While ACHAP supports other initiatives, namely the Harvard AIDS institute, to train physicians, nurses, and lab staff, and has expanded the hospital network by providing clinics and testing facilities in each province, there still is not enough medical personnel and infrastructure to accommodate the needs.

Another reason for the discrepancy between enrolled patients and the number of those who receive treatment is that medication is only prescribed by trained physicians and only pharmacists can dispense the drugs. This condition was set by Merck to ensure the proper administration of the medication. However, it means that staff time is being directed away from the hospitalized to walk-in patients who need a refill. A long wait time is almost unavoidable. This in turn affects the rate of adherence, as many infected spend so much time at the clinic that their bosses are reluctant to allow the infected to go and get their prescription filled on a workday. The infected then do not get new medication when they need it but when they are able to find time to pick up the drugs. (Hardon et. al., 2007).

Culture

This initiative needs to bridge cultural barriers in order to be successful. Rather than being an outside agency dictating what to do, ACHAP works closely with the Ministry of Health. Providing Botswana with ownership and responsibility for the success of the program helps to overcome skepticism caused by experiences made during colonial times.

In order to successfully educate the population about HIV and AIDS, training programs have to be designed with the local culture in mind. Reproductive health classes need to accommodate religious and cultural inhibitions, yet should address every day realities faced by Botswanis (e.g. traditional healers). Efforts need to concentrate on changing patterns of sexual behavior, only by which a spread of the disease will be limited.

Criticism

Many critics argued that an ARV therapy will not be a viable paradigm to fight HIV and AIDS in Africa. Too many obstacles, such as the cost for treatment, difficulties to adhere to the program, and the lack of trained medical personnel, would prevent any nationwide intervention from succeeding (Bill and Melinda Gates Foundation, 2006). The partnership had no role model it could rely on, and as an official with the Ministry of Health stated, "One of the problems was that we could not learn from anyone. "Everything had to be started from scratch" (Ramiah & Reich, 2005, p. 546). Subsequently, all decisions that were made were made with the best intentions, but had to rely on a trial-and-error methodology.

Results and Implications

ACHAP is now in its eighth year of operation. In 2005, Merck and the Gates Foundation decided to contribute another U.S. $6.5 million each to continue the partnership for another five years until 2009. Due to the inter-relatedness of malaria, tuberculosis (TB), and AIDS, the partnership has now expanded its efforts to include a tuberculosis program.

By the first program phase, it became apparent that just over half of the allocated U.S. $100 million were actually spent. The Gates Foundation attributes this to the limited "absorptive capacity" of the country (Bill and Melinda Gates Foundation, 2006, p. 6). It takes time and expertise first, and then money, to build the capacity of a country and the partnership acknowledges that it had underestimated the spending capabilities.

The latest available data shows that by the end of 2006, 79,490 patients were receiving ARVs. This means that 72.2 percent of the people eligible for treatment are receiving the life prolonging medication (ACHAP, 2006). The adherence rate is between 85 to 90 percent, a significant number considering how difficult it can be for the infected to take their medication on time (for a detailed study on ARV adherence see Hardon et. al. 2007). However, as Hardon (2007) states, "extremely high levels of adherence (at least 95%) are key to ensuring positive treatment outcomes and preventing the development of drug-resistance" (p. 658). It should, therefore, be a key interest of the partnership to make sure that every patient is taking the medication on time. Second-line treatment costs about ten times as much as the first-line treatment, which Merck is providing for free (ibid.). It would be the responsibility of the Botswanan government to purchase these drugs because their provision is not part of the ACHAP agreement.

ACHAP played a vital role in reducing the HIV prevalence among 15 to 19 year olds between 2003 and 2005 by 22 percent (ACHAP, 2006). Its focus on capacity building with regard to medical personnel also helped to lower "the percentage of HIV-positive infants born to HIV-positive mothers from an estimated 40% at inception of the programme [sic] to about 6% as indicated by a study in one major site in 2005" (ibid., p. 4).

The partnership is funded until 2009, however it is not clear what will happen after the partnership agreement runs out. The question remains whether or not the government of Botswana is able to sustain the initiative out of its own resources. This was the initial goal of the first five years of collaboration, however one reason to extend the partnership was the inability of the government of Botswana to take over and provide the funds necessary to sustain the program. Patients on ARVs have regained strength and are able to be part of the workforce again. Their treatment will be a lifelong effort, both in terms of actually prolonging the life and in limiting the chance of adherence. It is the responsibility of the government to assure these people are being supported in their fight against the disease.

Even if the epidemic has reached its peak in Botswana, it will take time to regain the economic strength the country once exhibited. However, ACHAP has demonstrated that a nationwide ARV program can work, if it is being administered correctly. While ACHAP provides no "one-size-fits-all" solution to fighting HIV/AIDS in sub-Saharan Africa, lessons learned have to be applied to future endeavors of this scale. The partnership has demonstrated that initial setbacks as well as a North-South-power struggle complicated the first years of operation. Only when mutual trust has been gained can any initiative make progress.

CONCLUSION

This public-private partnership is a pilot initiative that set out to fight HIV/AIDS in Botswana. Critics argued that such a large-scale ARV program would not work, given the existing infrastructure and social problems. Now, in its eighth year of operations, ACHAP has demonstrated first successes and proved critics wrong. Yet, ACHAP has not reached its goals yet. Not all AIDS patients have access to treatment and it will take more time and expertise to provide everyone with the adequate care needed.

Policy makers and nonprofit professionals can use ACHAP as an example to study how actors from all three sectors can work together in order to achieve a common goal. However, the partnership cannot just stop. An ongoing implementation of the programs is necessary to effectively fight the disease in Botswana and to re-enable growth. A virus-free generation could help Botswana to become again what it once was.

Partnerships and international aid monies cannot substitute for a lack of national commitment to investment and capacity building. Growth and development can only be achieved if all parties involved recognize the need to work together toward a common goal. The government of Botswana needs to maintain a strong leadership to fight AIDS in its country. Merck and the Gates Foundation need to carry through with their commitment to fighting HIV/AIDS alongside the government of Botswana.

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