

A Future beyond HIV/AIDS? Health as a Political Commodity in Botswana

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Abstract: Referencing scholarly debates on humanitarianism and specifically HIV interventions, this article analyses the commodification of health in Botswana's political arena throughout the HIV pandemic and beyond, contributing to a re-evaluation of the distribution of public wealth and international support in welfare states in Africa. The starting point of the analysis is a project to build a private hospital – a move to create a centre of excellence exclusive of international HIV/AIDS donations – and the staging of political responsibilities around it. Public investment into private health is an attempt to reform infrastructures built with HIV/AIDS money and to develop a market of high-paying jobs within the country. This process transforms the inalienable and indivisible condition of health and survival into a political commodity.

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In January 2010 the new Bokamoso Private Hospital opened near Gaborone, the capital of Botswana. *Mmegi*, the national newspaper, announced the opening enthusiastically with the headline “Towards a new era in health” (*Mmegi* 2010a). In Setswana, one of Botswana’s official languages, *bokamoso* means “future”; the construction of the private hospital symbolised the start of a healthy and prosperous future for Botswana. By November 2010, however, Bokamoso had already gone bankrupt, and the Botswanan government was called upon to assume financial responsibility for the sum of 250 million BWP (36 million USD) (*Mmegi* 2010b). The resulting public controversy and the staging of political responsibilities concerning the project (which was actually designed for private patients, not public health care) indicate that health has become a highly sensitive issue in Botswana’s national political arena.

The construction and planning of Bokamoso took place in the shadow of the country’s HIV pandemic. With an estimated 30 per cent HIV infection rate among the adult population, the country has one of the highest HIV prevalence rates in the world. Furthermore, Botswana is one of the few middle-income countries in Africa. Since independence, successive governments have managed to build a welfare state, allowing many of the estimated 1.3 million citizens (Botswana Statistics 2011)¹ to benefit from the country’s sudden wealth, derived from mineral processing in the 1980s.

Over the past few decades, with the help of international donors and private domestic companies, the Botswanan government has dedicated significant effort to HIV/AIDS prevention and care, investing a large proportion of public spending in health care under the administration of President Festus Mogae in particular. This has won Botswana the recognition and admiration of international politicians, and the country is often pointed to as an example of good governance and good public health care in Africa. The construction of the Bokamoso Private Hospital took place a decade after the implementation of a nationwide programme for the distribution of antiretroviral (ARV) drugs and was made possible by financial support from the national health insurance system. In this way, Bokamoso indicates a move beyond the HIV/AIDS health care that has been sponsored in large part by international donors. As a project drawing upon national resources rather than foreign donations, it

1 According to official statistics, the population size was estimated to be 1.3 million in 1991 with continuous growth until 2012 (Botswana Statistics 2011). Other sources estimated the population to be 1.9 million in the 1990s. One problem with these estimates is that absent men are often not counted, and migrants from other African countries are likewise omitted.

might also be seen as a move towards a new future of high-quality health care. In the following sections, I will discuss the interplay between various domestic and international political forces in placing survival and health on the political agenda of the Botswanan welfare state and address the country's attempt to move beyond an HIV-related political economy.

My contribution is based on ethnographic fieldwork among educated professionals in Gaborone, Botswana: Many of my informants are civil servants, some in the fields of HIV/AIDS and health care. The topics of my research, which took place over several visits to Botswana between 2009 and 2011, were family planning, elite lifestyles and HIV/AIDS. In the course of my fieldwork, I conducted over 80 biographical interviews with educated professionals from three generations on reproductive matters, health, family planning, their careers and their visions for the future. In this contribution, I attempt to develop an argument concerning health as a political subject and the re-evaluation of life through national politics in the era of HIV/AIDS beyond local social practices related to HIV/AIDS and reproduction. My reasoning is primarily based on interviews with officials, newspaper articles, policy reports and other statistical materials that I obtained over the course of my research or that are available online.²

Humanitarian Politics and the Commodification of Survival: Concepts and Contexts

An entry point for the discussion of the importance of health in twenty-first-century politics is provided by scholarly debates on humanitarian aid. These debates have helped create an understanding of how “health” has been introduced to the agenda of national and international politics and offer a contextualisation and conceptualisation of the struggle for health in Botswana.

2 This contribution is based on a paper I wrote at the Department of Social Sciences at the University of Konstanz during my stay as a Junior Fellow at the Centre for Advanced Studies. I thank the Centre for its generous scholarship and inspiring atmosphere. This research was made possible by the support of the Fritz Thyssen Foundation and the Max Planck Institute for Social Anthropology, Halle. It was conducted in affiliation with the Department of Social Sciences of the University of Botswana and with the permission of the Ministry of Labour and Home Affairs and the Ministry of Health of Botswana, the Gaborone Private Hospital (Dr. Music and Dr. Eaton) and the Bokamoso Private Hospital (Dr. Abebe). I thank all the institutions and people involved who have supported my research both financially and intellectually.

Humanitarian aid is not exclusively focused on people's health; it also targets relief and life-saving measures in situations of man-made disasters (such as wars, genocides, environmental catastrophes or mass exoduses of refugees) and natural catastrophes (such as flooding, tsunamis, earthquakes or famines) in which the people affected have a limited capacity to react. Over the past century, humanitarianism has become a powerful tool in international politics. Its political role has been consolidated by the growing importance not only of international organisations such as the International Committee of the Red Cross and Caritas, which broadened their scope of action after World War II, but also of political organisations including the Office of the UN High Commissioner for Refugees (UNHCR), the UN International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO), which gained influence in international politics in the post-war period (Fassin 2011; Bornstein and Redfield 2010). With strong roots in Christian and Enlightenment ethics of compassion, these interventions operate with an "emergency" mindset and are explicitly designed to ensure merely the survival of people (Fassin and Padolfi 2010) – often discussed under the keyword "politics of life". The politics of life, which includes HIV intervention, thus attributes a new political value to survival, as opposed to interventions that address the social value of life.

Throughout the twentieth and twenty-first centuries, health has been an important concern of humanitarian relief, primarily in war zones but also in refugee camps and other places where people have limited access to health care (Malkki 1996; Redfield 2005). By the turn of the millennium, health gained immense importance in international politics, as HIV/AIDS had become a priority for international health intervention programmes. The wave of death that fragmented the demographic composition of many affected societies, most of them in East and Southern Africa (Iliffe 2006), caught the attention of international politics and prompted calls for immediate action (Hardon and Dilger 2011). After the epidemic came to be perceived as a threat to national and international security,³ the US released 15 billion USD over a five-year period (2003–2008) for HIV/AIDS prevention and care through the President's Emergency Plan for AIDS Relief

3 The unclassified publication entitled *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*, commissioned by the Bush administration and released by the National Intelligence Council (2002), was influential in the founding of PEPFAR. This work was significant because it discussed the mortality that would be associated with a poorly controlled HIV pandemic across several decades and also predicted the impact of this excessive mortality on US national security interests.

(PEPFAR). In a similar vein, international organisations such as the UN and the World Bank joined the fight against HIV/AIDS, also employing the rhetoric of war. For instance, UN Secretary General Kofi Annan spoke about HIV/AIDS as a devastating disaster for many African societies:

By overwhelming the continent's health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability. (UNAIDS 2000, cited in Hardon and Dilger 2011: 144)

Subsequently, major sums of money were earmarked for HIV/AIDS prevention and care, especially for the purchase and distribution of antiretroviral drugs and medical expertise. These medications can significantly prolong the lives of HIV-infected people, but such therapies are cost-intensive, ranging between USD 300 and 1,200 for each patient per annum. Currently, HIV/AIDS support and research are entering a new period. The focus on HIV/AIDS has resulted in the neglect of other infectious diseases with equally deadly outcomes (such as onchocerciasis or schistosomiasis) that are most often found in resource-poor settings. With many African countries now able to provide ARV treatment to their citizens (UNAIDS 2013) – despite periodical stock-outs in some countries such as Uganda (Park 2012) – many programmes have responded to this critique by devoting support to other urgent health issues. This trend has been accompanied by a certain weariness on the part of the academic community with regard to HIV/AIDS. All these developments have come together in what I refer to as the post-HIV era. However, this does not mean that HIV/AIDS has vanished or even that infection rates are falling in places like Botswana.

The economic underpinnings of this politics of life have attracted scholarly criticism; in the case of HIV prevention and care, this has primarily revolved around the involvement of the pharmaceutical industry. For instance, the literature points to the ambivalent role of the state when signing contracts with pharmaceutical companies to enable the distribution of antiretroviral therapies (Biehl 2007), as well as at the “neoliberal world order” represented by the purchase of pharmaceuticals (Comaroff 2007).

A detailed analysis of economic exchange relations in the field of humanitarian aid is provided by the anthropologist Peter Redfield (2012), who shows that humanitarianism can involve an entire chain of market interactions. He describes a business model encompassing companies in the global North as well as the global South that is designed to bring humanitarian devices (such as Lifestraw, a portable, easy-to-use filter for contaminated water) to those in need. Companies invest in the marketing of

these devices and enable the implementation of humanitarian measures where governmental means and commitment to the well-being of citizens are lacking. Redfield describes how life-saving technologies are transformed by those marketing them into devices that look fashionable, thus appealing to potential consumers; one example of this is the aforementioned, easy-to-use water filter that looks and acts like a straw. These devices circulate within trading chains that stretch from countries where the advanced technology is developed and produced to places where it can save lives and is in high demand. These dynamics of the market effectively turn humanitarian technologies into humanitarian goods, Redfield argues. The market is transforming the ethics of survival and its related technologies into commodities, and turning those in need into customers and participants in the market exchange.

Redfield describes the commodification of humanitarian technology in and through global politics and corporations and in the shadow of weak states. By contrast, the case I seek to explore involves a strong welfare state and its collaborations with international donors, some being agents of foreign governments (such as PEPFAR), others of private enterprises (such as the Bill and Melinda Gates Foundation). My contribution pursues the question of the commodification of health through welfare politics and thus offers a new perspective on the debates over humanitarian aid and health interventions in the context of HIV/AIDS in Africa.

Botswana: Well-being after Independence

Botswana is one of the few middle-income countries in Africa. Its wealth derives from diamonds, an industry owned by the state, which has been processing the gems since the mid-1970s. To date, Botswana's economic growth is most visible in the city of Gaborone, where newly constructed shopping malls, fashionable restaurants, well-built roads and flashy cars dominate the cityscape. Soon after the Botswanan government started processing diamonds by sub-contracting South African mining firms, the country's public wealth soared. In the mid-1980s, the country had the fastest-growing gross domestic product (GDP) in the entire world (Werbner 2004).

Since then, the well-being of its citizens has been the top priority in Botswanan national politics. The former British protectorate had a poorly developed infrastructure when it gained independence in 1964; following its economic growth spurt, the Botswanan government invested heavily in the building of public infrastructure, specifically roads, schools and hospitals. Additionally, the government provided free education and public

health care for all citizens. Consequently, Botswana is now a comparatively high-functioning welfare state in which many profit from economic growth.

In addition, Botswana was praised for its peaceful move towards democracy under its first president, Seretse Khama (1966–1980), who managed to bring together the eight *kgosi* (Setswana: “chiefs”) of the eight principal ethnic groups to support a democratically elected parliament and create effective public services under his presidency. In fact, researchers have verified the redistribution of wealth and power since independence (Acemoglu et al. 2001). The government’s integrity in building a welfare state that is focused on the well-being of its citizens has been a surprise to many observers of African national politics; along this vein, Botswana has often been referred to as “the African miracle” (Cook and Sarkin 2010; Jerven 2010).

Recent developments, however, seem to dim Botswana’s bright prospects. The price of diamonds dropped nearly 90 per cent in 2008 (AEDI 2014). As a consequence, the country experienced a drastic cut in all areas of public spending. For instance, student admissions were halted in 2010, and salaries were not adapted to inflation, resulting in strikes of medical personnel in 2011 and 2012. In addition, the transparency of Botswana’s state bureaucracy has been contested in the country’s own public sphere (*Sunday Standard* 2011). The tense financial situation overall exacerbated Bokamoso’s financial troubles and fanned the flames of the public debate around the building.

Botswana’s dedication to welfare further manifested in the founding of national health insurance in the 1990s. As one of the first countries on the African continent to facilitate it, Botswana began its private health insurance scheme in 1969. The Botswana Medical Aid Society, BOMaid, is a not-for-profit society which drew its initial membership from audit firms, parastatals and banking organisations in Botswana. Two further health insurance schemes were founded in the 1990s: The Botswana Public Officers Medical Aid Scheme – BPOMAS, a health insurance programme covering all Botswanan governmental employees (junior and senior staff), their partners and children, and the Pula Medical Aid Fund, which offers medical aid to the employees of private companies and their families. Beyond this service, health insurances offer an additional tariff for “serious diseases”. With these health insurance schemes, people employed in Botswana have good access to health care even beyond the public health care system, the latter offering free primary care to all citizens of Botswana.

With the outbreak of the HIV/AIDS pandemic, health care advanced to being a prime priority in Botswana's domestic politics, as I will show in the following.

The Political Value of Life: HIV/AIDS, the Economy and Politics (1999–2008)

When I visited Botswana for the first time in 2009, HIV was already present in the public sphere, and many of my discussions with colleagues centred on the pandemic, prevention and health care. In brief, talking and thinking about HIV/AIDS had entered the public sphere in Botswana, and discussing the pandemic was accepted behaviour among academics. However, this does not mean that the stigma of HIV/AIDS had vanished or that people would openly speak about their own HIV infection status, at least not in these discussions.

Up until the mid-1990s, this was not the case. The first HIV infection was recorded in Botswana in 1985. Civil servants and public officials from the ages of 60 to 80 whom I interviewed in the course of my research appeared quite detached from the effects of HIV/AIDS in those years, even those who had worked in the health sector. HIV prevention programmes had been launched by the end of the 1980s; however, in those early years, public initiatives such as the advertising of safe sex and testing were mostly restricted to urban areas (Heald 2006). In rural areas, many people called HIV/AIDS the “radio disease”. In fact, observers attest that in academic circles, people still were reluctant to speak about HIV/AIDS in as late as 1997.

By that time, the pandemic's impact was already visible. HIV prevalence rates accelerated after the mid-1990s. By the end of the 1990s, the wave of death had shaped the demographic composition of Botswanan society, reducing the number of people in their reproductive and productive primes. “People were dying like flies”, said a colleague and friend of mine who returned to the country from a Ph.D. programme in the US in the mid-1990s. The death toll reached a peak in 2001, with an estimated 25,000 HIV/AIDS-related deaths in a population of approximately 1.7 million (Statistics Botswana 2011: 18). The life expectancy at birth was estimated to be between 42 and 47 years (Bulatao 2003: 78).

The social impact of the HIV/AIDS pandemic on affected societies such as Botswana is complex. Because the disease is deadly and leads to long and painful suffering if untreated, the pandemic has been described as creating tremendous physical as well as social hardships for the afflicted, especially in the 1990s before the development and proliferation

of ARVs (Fassin 2007). Some authors have also pointed to the associated economic impact resulting from the mass deaths of people in the prime of their lives, which left the elderly and children with nobody left to care for them (Iliffe 2006). The effects of HIV/AIDS were most visible at the household level, with new forms of households (with children or grandparents as heads) emerging (Ingstad 2004; Miller et al. 2007).

The first initiatives to obtain accurate information on the prevalence of HIV and, more important, to provide care for those affected by the virus were launched by mining companies. Merck & Co., a mining company in Botswana, conducted anonymous but obligatory testing among its labourers, which revealed a shocking HIV/AIDS prevalence of 59.1 per cent; as a result, the firm offered its labourers ARV treatment free of cost (Barnett et al. 2002: 19). The executives who initiated this programme expressed an economic rationale for its implementation. The treatment was intended to enhance staff productivity, as the company had begun to experience losses in productivity due to the frequent illnesses of workers and long sick-leave absences. Treatment was restricted to the labourers and explicitly excluded their families (interview with Tsele Fantan,⁴ September 2011).

Merck's treatment programme was designed to create "able bodies" – that is, people with healthy bodies who would be able to work and be productive. This echoes the historical experience through which perceptions of health and the body have been re-shaped by the integration of workers into wage labour (Livingston 2005).

Under the presidency of Festus Mogae (1998–2008), HIV entered the national political arena and subsequently the public sphere as well as the education system. Within Botswana's academic circles, President Mogae was seen as lacking political popularity at the beginning of his presidency, but his popularity grew as he instituted rigorous political action to combat the pandemic. In 2000, he made the following public declaration about the pandemic, telling reporters:

We really are in a national crisis. We are threatened with extinction [...]. People are dying in chillingly high numbers. We are losing the best of [our] young people [...]. It's a crisis of the first magnitude, it's a tragedy. (*The Telegraph* 2000)

These words reflected not only the national situation – as described above – but also the international rhetoric on HIV/AIDS as a disaster and a threat to security. In resonance with humanitarian ethics, Mogae initiated a na-

4 Tsele Fantan was the head of human resources at Merck and in charge of the introduction of the internal ARV-distribution programme.

tionwide programme that enabled every citizen to access ARVs free of charge. Botswana was the first African country to set up nationwide coverage for ARVs.

To his credit, President Mogae united the already-existing initiatives to provide the treatment programme begun by the mines with internal political support and international donors. Mogae initiated the foundation of private–public partnerships called ACHAP, or African Comprehensive HIV/AIDS Partnerships. These partnerships linked private initiatives which provided treatment with the government of Botswana and with a number of private and public foreign partners, among them the Gates Foundation, PEPFAR and the Harvard Institute. On its website, the Gates Foundation expresses a rationale for its support which is congruent with the mine’s interest in a healthy and productive population. The Foundation’s home page indicates that “health” is one of the important issues that Bill and Melinda Gates wish to address. The caption “We believe every person deserves the chance to live a healthy, productive life” appears next to a picture of “a Zambian man hold[ing] up his HIV-negative test results” (Bill and Melinda Gates Foundation 2014). In other words, their project to improve health serves to advance personal capacity and productivity, and thus aligns itself with the neoliberal conviction that strengthening individuals’ capabilities to enhance their social position is to the benefit of the entire nation or community in question.

The mining company Merck provided the medical infrastructure for the ARV programme. In the 1980s and 1990s, the mines ran hospitals with excellent reputations: My informants reported that these hospitals offered high-quality medical care, the best in the country. Merck also agreed to donate antiretroviral medicines for the duration of the partnership. In addition, Merck, in cooperation with the Gates Foundation, donated large sums of money for the construction of medical infrastructure. In total, the Merck Company Foundation and the Gates Foundation donated 106.5 million USD to the partnership. Both foreign and private investment into the health of Botswana’s citizens has been enormous. This country, with its 1.7 million inhabitants, has received approximately 23 per cent of the total funding that the Gates Foundation has committed to the fight against HIV/AIDS worldwide – namely, 2.5 billion USD (Bill and Melinda Gates Foundation 2006). This makes Botswana one of the main recipients of the Gates Foundation’s financial support. These sums are supplemented by donations from PEPFAR, which has contributed approximately 300 million USD since 2004, with a single-year peak of 93.2 million USD in 2008 (PEPFAR 2008: 15). These numbers and figures provide evidence of the international financial in-

vestments supporting the political will to create a healthy nation and to put an end to suffering and death.

The initial uptake of the ARV programme in Botswana was slow. In the first year of its implementation, the country hoped to enrol 19,000 people in ARV programmes, but only 3,200 were enrolled. The problem of low response continued until a new routine testing policy went into effect in 2005. This law mandates⁵ the testing of all patients admitted to the hospital as well as all pregnant women receiving prenatal care. The new policy marked a turning point, and the acceptance of ARVs has grown, despite the fact that outreach in rural and remote areas is still poor (Bill and Melinda Gates Foundation 2006: 4). An analysis of the online documentation makes it clear that it was not the able, the infected or the healthy body but the treated body that was the focus of political attention in 2006; political success was measured by the number of people receiving ARV treatments.

ARVs have changed how people experience HIV/AIDS. Patients with symptoms of full-blown AIDS have reportedly recovered to the point where they look like normal, healthy people. Given the right medication and adherence to a particular regime of care, HIV-positive people who take ARVs can have the same life expectancy as healthy people. In addition, controlled therapies with ARVs reduce the infectiousness of HIV-positive individuals to a minimum (Vernazza et al. 2008). When prescribed to pregnant women, ARVs generally inhibit the virus's transmission from mother to child. This enables people infected with HIV not only to take part in life again, but also to form families and have children without running the risk of spreading the infection (Meinert et al. 2009). The fact that HIV-positive people can live an almost-normal life again has been met with much enthusiasm as well as scepticism and criticism. On the positive side, not only can the physical suffering from HIV/AIDS be reduced, but the social damages – exclusion and stigmatisation – may also be mitigated as HIV becomes a chronic (rather than fatal) disease. That means that HIV-positive people can be fully integrated into society. However, this positive effect on the patients has also been accepted only cautiously by many public health providers, as it contributes to the invisibility of HIV/AIDS.

By 2009, when I started my research, ARVs were a complete success in Botswana: 98 per cent of babies born to HIV-positive mothers were HIV-negative at birth. Population growth had picked up again, staying at

5 An opt-out clause does exist but is rarely communicated to patients. Pregnant women who reject testing can be held responsible if their babies test positive. They may also lose their right to treatment.

two million in 2011. This is an increase of 100,000 compared to 2001. Above all, treatment has led to what public health experts have called the “normalisation of HIV/AIDS” (Roura et al. 2009). Approximately 20 of 70 people I conducted biographical interviews with between 2009 and 2011 were HIV-positive.⁶ Many of them had experienced fertility problems but apart from this had led normal lives following their infection with HIV: They had good jobs, were active members of churches and participated in the social lives of their families and friends. Nothing external indicated that they were HIV-positive, and for the most part they had not disclosed their serostatus to their social network.

Scepticism surrounding the ARV programme – specifically, concerning the “sustainability of ARVs” – has come in the form of criticism by policymakers and public health specialists, some of whom have expressed doubts in informal conversations as to whether Botswana is still in a position to provide treatment for all of its citizens. The question of “sustainability” of treatment has gained urgency in view of the fact that international sponsorship was due to run out in 2010, though Merck decided to extend the programme until 2014, providing an additional 30 million USD towards that end (Developing World Health Partnerships Directory 2012). However, compared to the 106.5 billion USD donated before, this amount translates into a considerable cut in supporting HIV/AIDS medicine and care.

To sum up, in order to ensure the survival of its population, health became a top priority in Botswanan national politics, in collaboration with international organisations and private companies’ initiatives to provide treatment. President Mogae mobilised considerable resources, using rhetoric that depicted HIV/AIDS as a national disaster and stressing the necessity to save lives. Private–public partnerships such as ACHAP and individual donors such as the Gates Foundation formed the core of these initiatives, shifting the rhetoric by emphasising that individual “health” is the key to individual and national productivity and by measuring political success by the number of treated citizens. This important political moment not only indicates a shift from well-being to health but also provides an example of national HIV intervention. In the course of the past fourteen years, the political rhetoric has changed from saving lives to providing treatment as a means to enhance the productivity of Botswana’s citizens as well as the quality of life of HIV-positive people. Health represents the focus of political efforts, but it also gains

6 Either they indicated this themselves or I was able to deduce it from their medical symptoms.

new value as a public good validated through transactions involving enormous sums of money flowing into the construction of medical infrastructure and the provision of ARVs.

Investment in the Future: Health beyond Survival

In the context of the HIV/AIDS pandemic, Botswana's health infrastructures were developed with national and international funding. Health also represents the largest public expenditure. By 2010, health services and maintenance received 40 per cent of public spending; HIV/AIDS and the high cost of ARV treatments contribute considerably to this high percentage. In fact, the public health care system is confronted with a number of other health problems, only some of which relate to HIV/AIDS.⁷ These, as I show in the following paragraph, have become pertinent in recent years.

When Ian Khama came to power in 2008, it was already expected that international sponsorship would be limited; most international programmes were planned to end in 2010 and subsequently extended only through 2014. Although the pandemic had contributed considerably to the building of the health care system, the new government was forced to handle its health costs with limited external support. Despite these conditions, the new government continued to prioritise health. This was indicated by Khama's opening speech before Parliament in December 2008. He announced that a "health hub is being established to identify projects and programmes that will make Botswana a centre of excellence in the provision of health services" (*Mmegi* 2008). In order to do so, the new government aimed to outsource health services to private operators, reasoning that this would allow the country to attract and retain specialists. One project designed for that purpose was Bokamoso Private Hospital (*ibid.*).

The Bokamoso project was intended to enhance health care, as the new centre of medical excellence would strengthen medical expertise within the country. In addition, the project's initiators hoped to attract patients from the entire Southern African region and thereby export health services beyond the borders of the national state. In an interview in 2010, Kabelo Ebineng, director of Botswana's sponsoring agencies,

7 An HIV infection heightens the risk of a number of other ailments, some of which can be assumed to be epidemiologically induced. Examples include cervical cancer (Livingston 2012: 43-46) and infertility.

pointed out the innovative role Bokamoso would come to play in Botswana's health care system, as it would offer certain medical services and technologies – for instance, in radiology and pathology – for the first time in the country (*Mmegi* 2010a).

Khama's programme marks a shift away from the sponsoring of HIV-related medicine and towards funding "health" in general, which is now receiving political attention, planning and financial support. The desire to invest in health facilities denotes changing political priorities. Health care beyond survival became the centre of political interest. The shift in political will and the re-evaluation of national health projects may be seen as a response to the cuts in international sponsorship on HIV/AIDS as well as to diversified health needs within the country.

As argued above, a large proportion of international and national HIV/AIDS money was invested into the building of medical infrastructure, including the training of qualified (medical) personnel and counsellors, formal education, and the development of educational programmes. International donations therefore not only facilitated the purchase of pharmaceuticals but also contributed greatly to building relevant medical infrastructures, all of which have bolstered the development of a market of high-paying jobs. Approximately half of my respondents were involved in HIV-related programmes or had acted as consultants on HIV/AIDS. This indicates that HIV/AIDS-related work is an important vocation for educated professionals. Broadening national expertise on health, as suggested by the new policy, would enable the country to maintain a market for highly qualified personnel of high-paying jobs in health facilities as well as in the Botswanan civil service. Considering that Bokamoso was scheduled to open in 2010, as the first period of ACHAP came to an end, its construction as a regional centre of medical excellence can be seen as a viable alternative to heavily funded HIV medicine.

In addition, the high demand on health services was also felt by patients in need. Access to ARVs and primary health care is free to all citizens of Botswana; however, many specialised services are not available within the public health care system. Patients have to be referred to specialised facilities. These can be private clinics or hospitals, the biggest of which used to be the Gaborone Private Hospital (GPH). Operational since the mid-1980s, the hospital offers patients a number of specialised health services, among them a gynaecology ward, a laboratory and three operation theatres for deliveries. For other services, such as radiology therapy, patients are referred to health facilities in South Africa or Zimbabwe and the costs are covered by the public health system. Radiology

therapy for cancer patients, for example, costs the government about 1,000 USD per treatment.

In a country the size of France but with a population of 1.5 to 2 million,⁸ developing health infrastructure that is accessible to everyone has always been a challenge. From 2009 to 2011, when I conducted my research, the need for more advanced medical technologies and services beyond primary public health care became clear to me. Princess Marina National Hospital has long waiting lists, and patients often feel that they do not receive appropriate care in a timely fashion. A good example is reproductive health. One woman told me that she had sought an examination for cervical cancer, but at Princess Marina she was put on a waiting list and given an appointment six months later. She felt uneasy about waiting such a long time for a consultation and went to a private health provider instead. This woman was only one case out of many. Whenever I visited the gynaecology station at GPH, the waiting room was filled with patients. Here, I had conversations with many patients who had travelled great distances in order to visit the gynaecologists in Gaborone. Some had even come from as far away as Francistown, situated approximately 450 kilometres north of Gaborone on the Zimbabwean border. These people usually take a day or even two off of work to receive specialised screenings and consultations on their personal issues.

A visit to a specialist requires expenditures far beyond average health costs. In addition to the cost of travel, patients have to pay the consultation fees themselves if they are unable to get a referral from the National Hospital (as was the case for the woman who thought she might have cervical cancer). However, the additional costs will be at least partly covered for a patient with private health insurance if they are referred by a general practitioner. A normal consultation costs between 200 and 500 USD and by far exceeds the average monthly spending on health care in households in urban areas (63.50 BWP, or about 8 USD; Central Statistics Office 2004: 23). Taken together, these circumstances demonstrate that, alongside public health care schemes focused on HIV/AIDS, a private health market supported by health insurance schemes has also been established in order to satisfy the health needs of those privileged groups able to afford it.

To sum up, with its 200 beds (to be expanded to 300), 20-bed intensive care unit, five operating theatres and 80 specialists, Bokamoso responded to the needs both of the public health care system to refer more patients into specialised care and of privileged groups – govern-

8 Estimates from 1985 to 2011 (Botswana Statistics 2011).

ment employees, civil servants and employees of other non-governmental institutions such as banks and insurance companies – who can afford private health care.

Only six months after opening, the hospital declared bankruptcy: The number of patients was below expectations, patients felt they had to wait too long to be seen and there were problems with the billing system as well as a number of other internal problems with management, the computer system, supplies and in other areas. In addition, observers noted that public health care patients were still referred to South African health providers rather than to Bokamoso. This demonstrates a lack of trust in this new private health facility by both the patients and the public health providers. When Botswana's medical health insurance for government employees, one of the institution's main sponsors, failed to cover the ever-increasing costs of the project, the government refused to fulfil requests from the hospital's management to cover the hospital's debt of 250 million BWP (about 36 million USD) and declined to respond to queries from the media as to the reasons it would not pay the debt (*Mmegi* 2010c). In November 2010 staff were cut, and those remaining were put on weekly contracts with considerably reduced salaries. That the hospital's management team was suddenly dismissed shortly afterwards suggests some internal tension between the government and those in charge of implementing the project (*The Monitor* 2011).

By 2011 a new sponsor from South Africa had been found. By then many of the specialists from the North had already left Bokamoso. It took the whole of 2011 to sort out Bokamoso's disastrous financial situation, and a report by an independent South African consultant revealed that the initial calculations had been too optimistic as they had assumed the hospital would run at full capacity from the start (*Mmegi* 2011). The hospital was taken over by the Lenmed Group in the first quarter of 2011.

Studying the financial structure is crucial to the analysis of a political system and its problems diversifying an internationally sponsored national health system built to treat HIV/AIDS and installing a domestically sponsored and self-sustaining centre of medical excellence. Bokamoso was intended to operate as a market-oriented enterprise, yet was a non-profit organisation according to its manager Kabelo Ebening (*Mmegi* 2010a). Its financing was secured through two main medical aid schemes in Botswana: BPOMAS, a closed medical scheme for government employees, and the Pula Medical Aid Fund, a private sector-oriented medical aid scheme. The government subsidises exactly 50 per cent of membership fees in both health schemes; therefore, commentators have speculated that the government has a strong interest in the project. Critics have pointed

out the contradictory financial interests that the hospital was subjected to in having health insurance companies as its primary sponsors. In fact, a factor in the hospital's financial disaster in November 2010 was the unpaid bills and doctors' wages owed by BPOMAS (*Mmegi* 2010d). Even though Bokamoso's services were open to all patients who could afford them and were supplemented by all health insurance schemes, because BPOMAS held an initial share of 80 per cent and was the main sponsor of the project, one can speculate that these health services were designed to provide for the health needs of government employees and those with capital, influence and power. On the other hand, it also suggests a strong public commitment to such an ambitious project and a political will to retain some of the country's past achievements in health services.⁹

Foreign involvement remained important for the project beyond international sponsorship. Bokamoso was planned in cooperation with two health institutions from the United States, which offered expertise in technology and management (*Mmegi* 2010d). Again, this was subject to public criticism as it employed many specialists from outside the country – among them, specialists from the US as well as other African countries – extracting qualified personnel from other health institutions. Medical personal was attracted (internationally and nationally) by high salaries, good working conditions and the promising prospects of being part of such an ambitious health project on the African continent. American staff were among the first to leave the country when an interim management team cut staff and adopted weekly contracts in November 2010.

To conclude, this ambitious project to build a centre of medical excellence on the African continent ushered in a new era in health in many respects. First, this turn towards viewing health as something beyond mere survival has brought about a diversification of health care services meant to respond better to the existing needs of those under the public health care system as well as those who can afford advanced private health services. It was this inability to both cater to public interests (for better and easy-to-access health care) and invest in private health care in order to capitalise on private health expenditure that led to internal friction and tension in Bokamoso. Although Bokamoso represents an attempt by Botswanan leaders to keep expertise and resources within the country, it will most likely strengthen already-existing health disparities between public and private health care.

9 The government's ambivalent position of sponsoring and supporting the project while rejecting requests for financial support after Bokamoso declared bankruptcy confused the public.

Second, the government's investments into private and specialised health care are in line with the norms of new forms of public–private partnerships. In the era of HIV/AIDS, international funding *and* expertise were brought to the country to support the construction of a health care system designed to ensure “survival”. Perceiving limits to international sponsorship, the new government as of 2008 took steps to keep the field of medicine a high-paying pursuit independent of international sponsorship by investing in ambitious projects such as Bokamoso. In public discourses, this step was saluted and welcomed as a step away from a dependency of the global South on the global North in terms of finance and knowledge. Being able to run an African-sponsored centre of excellence was seen as liberation from dependency on foreign capital.¹⁰

The initial failure of this new enterprise shows that realising the ambitious vision has come at a high cost. Many factors contributed to the bankruptcy, among them mismanagement, lack of trust in the hospital's services and strained public resources, all of which are not unique to Bokamoso or Botswana as a whole. However, the failure exposes both the paradoxes of this new public engagement with private health and the differing interests of various stakeholders playing out in this particular social and political environment of public–private partnerships that are creating a new sort of health economy.

Conclusion: Health as a Political Commodity

In a population in which an estimated one-third are infected with a deadly virus, health has to be actively produced. Referencing the debate on the economisation of aid politics, I have discussed the effective investment in the health of Botswanan citizens during the HIV/AIDS pandemic as well as the steps taken by the government in consideration of the future of health care in the post-HIV/AIDS era. At the beginning of the millennium, the political institutions of the welfare state in Botswana dedicated to the well-being of its citizens collaborated with international and national institutions to save lives. In the course of the implementation of HIV programmes, these institutions adopted the market-oriented rhetoric of productivity and recognised the national benefits of individual health. As has been shown, in the post-HIV era, health represents a commodity sought after by those who can afford private health care, and

10 This attempt was also met with scepticism, as “Africans” were believed to be “consumers”, as stated by a Botswanan reader in a Facebook thread on an article on Bokamoso's take over (*Mmegi* Facebook 2012).

some political initiatives have tried to reform existing infrastructures and launch ambitious health projects such as Bokamoso.

Here I would like to especially reference models of the commodification of humanitarian aid and link these with global political processes that have been observed since the beginning of the millennium: The construction of Bokamoso can be interpreted as an attempt to create a new health infrastructure in a public–private health economy, with the very product of its commodification being health.

Processes of commodification through and within politics have been observed in very different policy domains, often with respect to the study of armed conflicts. In their theory of “markets of violence”, Elwert and others suggest that armed conflicts are embedded in a cycle of violence that is motivated by the economic interests of the parties involved (Elwert 1999; Werthmann 2003; Schlee 2004). In relation to this theory, some scholars have shown that states or governments can engage in profit-oriented exchanges with, for instance, rebels or other powerful groups in society to ensure protection, security, peace or even human rights (Shah 2006; Raeymaekers 2010). In this way, individual rights and security may become elements in chains of profit-oriented exchanges, and governments may appear to commodify their citizens’ basic rights. With regard to HIV interventions in Botswana and elsewhere, we can add survival to the list of political commodities that drive certain political initiatives within and beyond the national state.

In theory, health care is an inalienable right. Public domestic spending on and international sponsorship of HIV/AIDS medicines turned the survival of Botswana’s population into a commodity. Public investment in private health care in Botswana is a politically supported attempt to reform existing infrastructures and maintain a market of high-paying jobs within the country independent of international sponsorship. This process transforms the inalienable and indivisible condition of health into a commodity, turning it into a subject of financial speculation. These processes contradict human rights discourses and theories about health as being in the “possession” of individuals and about individuals having the right to adequate access to health care independent of their social, religious or cultural background. In marketing health, the government of Botswana is creating a health-related political economy with new kinds of public–private partnerships that spans private consumption and political spending and augments not only the public benefit but also the private profits of the professional classes dedicated to health care.

The case of Botswana shows that at the beginning of the twenty-first century, some governments have turned into entrepreneurs and entered

into multi-layered exchange relations with parties representing global flows of capital, knowledge and ethics. Hereby, governments trade off the very product they are supposed to uphold according to their political mandate: the indivisible conditions of health, freedom and security of their citizens.

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Eine Zukunft jenseits von HIV/AIDS? Gesundheit als politische Ware in Botswana

Zusammenfassung: Mit Bezug auf die wissenschaftliche Debatte über humanitäre Hilfe, insbesondere im Zusammenhang mit HIV/AIDS, analysiert die Autorin die Ökonomisierung von Gesundheit in Botswana während und nach der HIV/AIDS-Pandemie. Damit trägt sie zu einer Wiederbelebung der Diskussion um die Verteilung öffentlicher Güter und die internationale Unterstützung für die öffentliche Fürsorge in afrikanischen Staaten bei. Ausgangspunkt ihrer Analyse ist ein Projekt zum Bau eines privaten Krankenhauses – eines regionalen Zentrums exzellenter Krankenversorgung, unabhängig von internationalen HIV/AIDS-Hilfsmitteln – und die damit verbundene politische Inszenierung. Über öffentliche Investitionen in die private Gesundheitsversorgung strebt die Regierung eine Reform der Institutionen an, die mithilfe von HIV/AIDS-Hilfsgeldern im Land aufgebaut wurden, sowie gleichzeitig die Schaffung hochbezahlter Arbeitsplätze. In diesem Prozess ist das unveräußerliche und unteilbare Recht auf Leben und körperliche Unversehrtheit zu einer politischen Ware geworden.

Schlagwörter: Botswana, Humanitäre Auslandshilfe, Wohlfahrtsstaat, Politische Ökonomie, Gesundheitspolitik, HIV/AIDS