THE (UN)MAKING OF NCD POLICY IN BOTSWANA: ACTOR MOBILISATION, INERTIA, AND FRAGMENTATION.

Thabo Lucas Seleke, MSc, MPA

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Department of Global Health and Development

Faculty of Public Health and Policy

London School of Hygiene and Tropical Medicine

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Declaration of candidate's role in the thesis

I, Thabo Lucas Seleke, confirm that the work presented in the thesis is my own. Where information has been derived from other sources, I confirm it has been indicated in the thesis. The entire thesis was designed, conceptualized, analysed, and written by myself while pursuing a doctoral degree at the Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine (LSHTM). Qualitative methods were applied through interviews and documentary analyses. Interviews were conducted mainly in Botswana remotely through Teams and Zoom, directly from London, UK. Informed consent and participant information sheets were approved and signed by the LSHTM Observational/Interventions Research Ethics Committee, the University of Botswana Ethical Review Board, and the Botswana Ministry of Health and Wellness Ethical Review Board. The PhD study course was supervised by Professor Dina Balabanova and Professor Susannah Mayhew.

Thabo Lucas Seleke

I confirm the accuracy of the above statement.

5th February 2025

Supervisors:

Prof. Dina Balabanova, Department of Global Health and Development

Prof. Susannah Mayhew, Department of Global Health and Development

Abstract

Background

The increasing burden of non-communicable diseases (NCDs) in sub-Saharan Africa is causing a further burden on healthcare systems that are least equipped to deal with the challenge. In Botswana, NCDs accounted for 38% of deaths in 2021. Despite this high economic, social, and human burden of NCDs, interrogation of the problem and policy responses in Botswana and sub-Saharan Africa more generally have been limited. Much of the literature from Botswana focuses on developing a successful HIV/AIDS policy, but this has not been used to inform the examination of NCD policy development. This thesis describes the NCD policy development process in Botswana. It examines the experiences of translating the 2011 UNGASS political declaration to national policies for the prevention and control of NCDs, the extent to which WHO "best buy" interventions for NCD prevention have been implemented, and the role of actors in shaping and constraining NCD policy development and implementation.

Methods

The study employed a qualitative case study design. A policy framework developed by Shiffman and Smith, which considers actor power, ideas framing the problem, political contexts, and issue characteristics, guided data collection and analysis. First, a review of literature and policy documents relevant to NCD responses in sub=Saharan Africa and Botswana was undertaken to determine the mandated policies, the agenda-setting, and planning, as stated in key documents. Twenty-eight semi-structured interviews were

conducted with key national-level informants who were decision makers in various sectors, including the government authorities, civil society, industry (private sector), and UN agencies. The key informants' narratives revealed the processes of formulating government-led NCD policies and their knowledge, insights, and experiences regarding the current state of policy development and implementation. Data were coded and analysed thematically, guided by, but not limited to, the Shiffman and Smith analysis framework.

Results

The NCDs prevention policy development process in the country is influenced by both global and local factors. The overarching issues emerging from the study are that while political will is considered to be important for NCD programme implementation, there are divergent views among the stakeholders interviewed on the extent to which political will is actually exercised in the response to NCDs and NCD risk factors, compared to the response to HIV/AIDS. Although the National Strategic Framework was developed to integrate NCD responses into health service delivery, it has not led to adequate resources and capacity to enable its implementation. There are also a lack of incentives and interest by the actors involved, both at the national and sub-national levels, to implement an effective NCD response.

The study findings also indicate that there is fragmented leadership and a lack of coordination by guiding institutions to translate policy into action. The study also found parallel activities by non-government actors and fragmentation between national bodies, which in turn lead to disconnection between national and sub-national implementing structures. These fragmented responsibilities led to structural problems hampering the NCD response.

The study also finds that the alcohol industry and medical aid insurance schemes are mostly profit-oriented, and their commitment to addressing NCDs is often tokenistic. Similarly, the youth and their organisations do not think NCDs relate to them. Civil society is also ineffective because civil society organizations are merely implementing agencies who rely on donor funding, but no such funding is forthcoming for NCD activities. Moreover, they are not driven by their own goals or vision on NCDs and do not have a strong presence or power to influence policy development or implementation processes.

Conclusion

The findings of this thesis illustrate various challenges in bringing sectors together to develop and implement the National Strategic Framework on NCDs to address the increasing NCD burden and risk factors. Unlike the response to HIV/AIDS in Botswana, which had a lot of political support and funding, the situation with the NCD response is markedly different. Stronger coordination mechanisms with clear guidelines for sector engagement are required for the effective implementation of NCD policies and programmes, drawing on the lessons from the HIV/AIDS strategies and programming. The health sector alone cannot achieve successful prevention and control of NCD epidemics. A wide range of organizations from multiple sectors and across government must be involved in implementing the necessary action on NCDs. The legacy of reliance on external funds and dependency culture created by the response to HIV/AIDS needs to be overcome, with leading institutions ensuring that NCD policies become an integral part of the health system of Botswana.

Key words: Non-communicable diseases, policy, health systems, Botswana, Africa.

Acronyms Index

Acronyms of organisations, groups and actors cited in the thesis

AIDS	Acquired Immune Deficiency Syndrome
ACHAP	African Comprehensive Partnerships
ART	Antiretroviral Treatment
ARV	Antiretroviral
AU	African Union
BAIS	Botswana AIDS Impact Survey Summary
BIDPA	Botswana Institute for Development Policy Analysis
BOCAIP	Botswana Christian Health and AIDS Intervention Program
BOSASNET	Botswana Substance Abuse Support Network
BOMA	Botswana Medical AID Society
BHP	Botswana Harvard Partnership
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CSA	Control of Smoking Act
CSR	Corporate Social Responsibility
CSO	Civil Society Organisations
CEN-SAD	Community of Sahel-Saharan States
DANIDA	Danish International Development Agency
DAC	District AIDS Coordinators
DC	District Commissioner
DDC	District Development Committee
DHMT	District Health Management Teams
DMSAC	District Multisectoral AIDS Coordinators
DRC	Democratic Republic Congo
EAC	East African Community
ECOWAS	Economic Community of West African States
EHSP	The Essential Health Services Package for Botswana
FCTC	WHO Framework Convention on Tobacco Control
GDP	Gross Domestic Group
GNP	Gross National Product
GoB	Government of Botswana
GBV	Gender Based Violence
MDG	Millennium Development Goals
MoHW	Ministry of Health and Wellness
MSA	Multi-Sectoral Approach/Action
MSF	Multi-stream Framework
HAART	Highly Active Antiretroviral Therapy
HIC	High Income Countries
HSS	Health Systems
HIV	Human Immunodeficiency Virus
IHME	Institute for Health Metrics and Evaluation
LEGABIBO	Lesbians, Gays and Bisexuals of Botswana
LMIC	Low- and Middle-Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
NAHPA	National AIDS and Health Promotion Agency
NCCC	National NCD Coordinating Committee
NCD	Non-Communicable Disease
NDP	National Development Plan
NGO	Non-Governmental Organization
NSF	National Strategic Framework
PEPFAR	President's Emergency Plan for AIDS Relief

PMTCT	Prevention of Mother to Child Transmission of HIV
PLHIV	People Living with HIV/AIDS
PHC	Primary Health Care
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	Special Session of the General Assembly
USAID	United States Agency for Implementation Development
UNDP	United Nations Development Program
SADC	Southern African Development Community
SSA	Sub-Saharan Africa
SMC	Safe Male Circumcision
SONA	State of the Nations of Address
TAC	Technical Advisory Committee
VDC	Village District Committee
VMSAC	Village Multisectoral AIDS Coordinators
WHO	World Health Organization

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Chapter 1: Introduction and overview of the thesis

The first part of the chapter (section 1.1) begins by presenting the background and rationale for this PhD thesis. It provides an overview of global initiatives to tackle NCDs, followed by an overview of the Botswana context and how it has helped shape the response to non-communicable diseases (NCDs) and their risk factors in Botswana. It then includes a brief analysis of the response to HIV/AIDS as a comparison. This is followed by a description of the structure of the two-tier health system in the country and how it has shaped health service delivery from the national to the sub-national level. Section 1.1. concludes with a summary of the rationale for the study. The second part of the chapter (section 1.2) presents the thesis aims and objectives, and section 1.3 presents the conceptual framework used to explain the policy responses to NCDs and related factors in Botswana. In section 1.4 I provide an overview of the key methodological approach of the PhD, an exploratory case study approach, and the strengths and shortcomings of the case study methods used in this PhD study. I then describe the structure of the thesis.

1.1 Background and Context

1.1.1 Global responses to the rising burden of NCDs

Following the UN Political Declaration on Non-Communicable Diseases at the 2011 United Nations General Assembly High Level Meeting (UNGASS), non-communicable diseases (NCDs), notably cardiovascular diseases, diabetes, chronic respiratory diseases, and cancer, have received greater recognition and attention globally and in sub-Saharan Africa (1). Since then the most important instrument guiding the global response to NCDs has been the WHO Global Action Plan "Best Buys" 2013-2020 adopted by WHO (2), as discussed in section 2.4. Previously, this had not been the case, as the focus of international efforts had been on responding to communicable diseases, particularly HIV/AIDS, and little attention was given to NCDs (1). Prior to the first High Level Meeting of the UN General Assembly on NCDs 2011, the global response to NCDs was led by the WHO and involved the successive development of instruments to guide national policy development (2). The UN Political Declaration of 2011 on NCDs created a momentum and policy window that called for concerted global action and for governments to respond to the NCD pandemic. The UN Sustainable Development Goals (SDGs) for 2030 have also played a significant role by firmly establishing NCDs as an urgent global health priority, which was conspicuously absent in the earlier Millennium Development Goals (MDGs) set

in 2000, by including them in SDG target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being).

UNGASS 2011 has drawn attention to the WHO Global Action Plan 2013-2020 “Best Buys” interventions that shifted the responsibility for action on NCDs to regional and national levels (3). The 2011 UNGASS and the WHO “Best Buys” interventions as well as the WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs called for joint engagement of all relevant government agencies, non-governmental organizations and industry in the response to NCDs; they put more emphasis on a Multi-Sectoral Approach (MAP) as they recognized that the pandemic could not be tackled by the health system level alone. It has been noted that translating global commitments into national action requires decisive political will and a whole-society approach that engages all partners in the response (4), (3). However, the literature from various studies on NCDs in sub-Saharan Africa shows that national-level progress has been inadequate (5). The WHO progress monitor also attests to this; for example, it shows that only 33% of countries have a National NCD action plan or strategy and only 31% have set national NCD targets and indicators (6).

NCDs were absent when the Millennium Development Goals (MDGs) were enacted in 2000, as global attention remained on maternal and child mortality and on communicable diseases. For example, in Botswana, the AIDS programme successfully partnered with civil society to deliver targeted HIV intervention programmes. Similar collaborations may have been possible in relation to NCDs but appear to be less common (7). Collins et al. (8) argued that despite mounting evidence that NCDs impede social and economic development, few resource-constrained countries have put in place mechanisms to respond to them, such as developing operational NCD strategies or services.

Whilst it is clear that the private sector could exert influence by promoting healthier commodities and not promoting commodities detrimental to health, it can also promote healthy workplaces, and improve affordability and access to medicines (9). The private sector provides guidelines and directions for countries to manage and implement tobacco control as well as prevent the harmful use of alcohol. However, the literature from different countries does not provide a detailed analysis of how the private sector can exert such influence. Examples of tobacco control and harmful use of alcohol are mentioned in

numerous global strategies and national action plans, demonstrating the potential impact of Multi-Sectoral Action Plans in the NCD prevention and control.

1.1.2 Botswana's NCD response

According to WHO, non-communicable diseases are the most common causes of premature death and disability worldwide (9). They were estimated to cause 35 of the 53 million deaths globally in 2011, with more than three-quarters of these deaths occurring in low-income and middle-income settings. Deaths due to NCDs are projected to increase by 15% by 2020 [1]. According to Tapela et al. (10) 34% of all deaths in sub-Saharan Africa in 2015 (3.1 million) were caused by NCDs. Letamo et al estimated that NCDs accounted for 31% of all mortality in 2008 in Botswana, with cardiovascular diseases being the most prevalent NCDs, comprising 14% of all deaths (11). While HIV has been a dominant issue in the country over the past decades, the government has recently formulated a comprehensive NCD strategy to deal with the double burden of infectious and non-communicable diseases. Despite this double burden of disease, the unprecedented and devastating impact of the HIV/AIDS epidemic in Botswana during the late 1990s placed the country at the centre of the fight against the disease, and the country became a globally well-known test case for effectiveness in the HIV/AIDS response (3). In comparison, the efforts to respond to NCDs have lagged behind.

While Botswana has been one of the most successful countries in terms of providing access to treatment for People Living with HIV/AIDS (PLWH), according to Sharma and Seleke (12), it was only in 2016 that Botswana developed the National Strategic Framework to respond to NCDs (13). The increase in NCDs and NCD risk factors is a great concern for a country where the population and health system are still experiencing the consequences of the HIV/AIDS pandemic. Prior to 2016, Botswana did not have a national policy or strategy for non-communicable diseases, (13) and according to Tapela et al. the only national policy instruments related to non-communicable diseases were the Alcohol Policy, Tobacco Policy, Nutrition Strategy, Essential Health Services Package, and the Botswana Public Health Act (10). However, these policies did not comprehensively address the prevention and treatment of non-communicable diseases. During the same period, before 2016, national clinical guidelines for non-communicable diseases were not available (13). Overall, the policy response to the growing burden of NCDs was slow and piecemeal, both in terms of the regulatory framework and service delivery. As a result of

this Tapela et al. argue that this resulted in the poor management of adults with cancer, diabetes and hypertension which were now increasing and becoming silent killers (13).

In Botswana, the burden of non-communicable diseases accounts for 38% of mortality and is similar to that of other countries in the region (10). For instance the WHO Report 2023 indicates that in South Africa 58% of deaths are due to NCDs, in Zambia 35% of deaths, Namibia 43%, Zimbabwe 35%, Lesotho 45%, and in E'Swatini 46%. Epidemiological data on the disease burden in Botswana and the WHO Steps Survey on NCDs show that both morbidity and mortality have been on the rise in the past decades (14), which called for government action to respond, and so after 2016 NCDs were included in high-level national strategy documents such as the 11th National Development Plan (2017-2023), Ministry of Health and Wellness strategy 2017-2023, the National Essential Health Services package, NCD diagnosis and management, and the National Strategic Framework on NCDs 2017-2023.

1.1.3 An analysis for comparison: Botswana's response to HIV/AIDS:

The first case of HIV in Botswana was reported in 1985 (15). The nation's response to the epidemic dates from the late 1980s with the Short-Term Plan (1987-1989) followed by the Medium-Term Plan I (1991-1996), which first promoted a medical and health system response to HIV and AIDS (12), (16), as described in the 2012 Botswana National Policy on HIV and AIDS. Sharma and Seleke (12) note that during this period, in 1992, the first National HIV and AIDS Policy was developed, with a shift to a multi-sectoral approach to addressing HIV and AIDS, and the Medium-Term Plan II (1997-2002) established the institutional structures considered necessary to organize and manage the national response. In addition, the National Policy was revised in 1998, (17). Botswana is therefore widely considered an exemplar in terms of a national public health response to the devastating HIV/AIDS pandemic as noted by Masire et al. (18), and Sharma and Seleke (12). The country implemented robust responses, and it became the first in sub-Saharan Africa to offer universal access to HIV care (12), [121}. Masire et al. have stressed that the country's response was unique and utilized a multi-sectoral approach to address the demands of the disease (18).

The evolution of the National Response on Botswana continued with the development of the National Strategic Framework (NSF) for HIV and AIDS 2003-2009, which guided action to address the epidemic during the period of the National Development Plan 9, (17). In 2010, the second National Strategic Framework (NSF II) was developed to outline national

priorities for the national response for the period 2010–2016 and aligned to the National Development Plan 10, (17). This national policy sought to provide the general principles by which the management of the national response to HIV and AIDS in Botswana could be guided. The Government of Botswana recognized that the most effective mechanism to halt the spread of HIV was to prevent new infections. To accomplish this task, the Government of Botswana ensured access to prevention information, techniques, and services to all persons.

The country's National Strategic Framework for HIV and AIDS serves as the ultimate strategic guide for Botswana's response to the epidemic and all programmes and interventions (17). The government of Botswana partnered with the National AIDS Coordinating Agency, NACA, for the national response to HIV and AIDS, by sharing relevant information that had been requested to assist with reviewing their contribution to response achievements and ensuring that a comprehensive overview of the national response was maintained (17). In 1999, Botswana had established the National AIDS Coordinating Agency (NACA) to develop and support partnerships, harmonize initiatives, and coordinate and facilitate the implementation of the national response to HIV and AIDS. Sharma and Seleke (12) show that during the first stage of responding to HIV, both counselling and testing were free and offered as opt-in services at government health facilities, however a lack of access to treatment and high levels of stigma undermined the value of testing for the average person. To promote the necessary coordination and management of the multi-sectoral national response to HIV and AIDS at all levels, formal coordination structures with appropriate human resources existed in the public and private sectors and civil society.

The President sought to develop partnerships with the international community to support HIV preventative strategies, help develop social support systems to address the fatal consequences of the disease, support scientific research for treatments, and improve access to ART for countries that were the poorest and most afflicted (12). The President also urged the nation to support the National HIV/AIDS Strategic Plan in Botswana, which encompassed a multi-sectoral strategy involving both the private and public sectors as well as significant investment from the government itself.

In 2002, Botswana established the Masa Program, a flagship national HIV treatment programme. Furthermore, in 2002, government officials collaborated with the Merck Foundation and the Bill and Melinda Gates Foundation to form the African

Comprehensive HIV/AIDS Partnership (12). Botswana adopted initial public messaging about HIV from PEPFAR, launched in 2003 to offer international aid for HIV programmes, particularly in sub-Saharan Africa (17). This messaging was meant to dispel the cultural and institutional features that had created resistance to HIV programmes in certain contexts, where HIV/AIDS was a taboo subject which inhibited effective implementation or uptake. According to Heald (19), the negative response to the first educational campaign stressing condom use is described and contextualized in terms of Tswana ideas of morality and illness. However, Western strategies such as the ABC approach ("Abstain, Be faithful, Condomize") were also not helpful for creating behaviour change in Botswana (19).

1.1.4 Botswana's economy and two-tier health system

Botswana is a landlocked country in Southern Africa, bordered by Namibia to the west and north-west with a short border with Zambia in the north, by South Africa to the south and by Zimbabwe to the east. The World Bank Report 2024 indicates that Botswana was one of the world's poorest countries at independence in 1966, but that it rapidly became one of the fastest-growing economies. Significant diamond wealth, robust institutions, prudent economic management, and a relatively small population of about 2.5 million (2022), have made it an upper-middle-income country with an aspiration of becoming a high-income country (20). The World Bank Report 2024 also indicates that Botswana's stable political environment includes a multi-party democratic tradition, with general elections held every five years. The ruling Botswana Democratic Party (BDP) has been in power since independence. The next election is scheduled for October 2024. The country reports also show that it is also relatively free of corruption and has a good record of human rights. Furthermore, the World Bank Report 2024 indicates that historically Botswana's macroeconomic policy framework has been anchored in prudent macroeconomic policies and solid economic institutions, particularly around managing diamond revenue. The revenue from diamonds has contributed to a long period of Botswana's positive economic growth.

However, Botswana's reliance on diamonds and a public sector-driven model have made the economy vulnerable to external shocks, as diamonds contribute to over 90% of total exports and are a major source of fiscal, (20).

Government health services in Botswana are delivered through a two-tier system, from the national to the subnational level. It is a decentralized model, with primary healthcare

being the pillar of the health care delivery system. At this level, there are also structures (district and village levels) responsible for ensuring the execution of health services delivery. Within the decentralized model, the institutional planning set-up can be divided into three levels, that is community level, district level and central government level. At the community level the focal point is the Kgotla, which falls under Tribal Administration. The Kgotla is defined by Serema (21) as representing the "institution" where commonly consensus can be arrived at and where development initiatives and participation can be encouraged. It is a traditional authority, with chiefs, sub-chiefs, village headmen and ward heads being critical links between communities and government authorities (21). All villages have a Kgotla and the village Kgotla is led by the Chief who is responsible for calling the Kgotla meetings, trying cases under customary law, and is involved in village development. It is at this level where there the Village Development Committee (VDC) and Village Health Committee (VHC) operate, and VMSAC, VDC and VMSAC are multidisciplinary (21).

The next institutional level is that of the District. At this level the most important institution is the District Administration, headed by the District Commissioner (DC) who is responsible to the Ministry of Local Government and is a senior representative of Central Government at the district level. He/she is the chairperson of the District Development Committee, which is in charge of preparing the District Development Plans, thus the coordination function of the DC is very critical (21). It is at this level where we also find District AIDS Coordinators who serve as the Secretariat for the District Multisectoral AIDS Committee (DMSAC), DMSAC are also critical as discussed in detail in Chapter 5. The District Health Management Team (DHMT) is also a member of DMSAC and also sits at the DDC. Tapera et al. (22) elucidated further by stating that the decentralized health system in the country functions through an extensive network of health facilities comprising hospital clinics, health posts, and mobile stops. In addition to these extensive health facility networks, there are 101 clinics that can cater to inpatients, 171 clinics without beds, 338 health posts, and 844 mobile clinics. Furthermore, and importantly in terms of access and affordability, citizens in Botswana do not pay directly for public sector health service delivery (22).

In Botswana, treatment guidelines on the management of all diseases are available in the Botswana Primary Care Guidelines which also cover the management of NCDs such as diabetes, hypertension, cardiovascular diseases, mental health and non-HIV related cancers in a primary care setting (23). According to Masupe et al., the NCD management

model remains that of addressing acute presentations of NCDs rather than long term risk factor management (23). Conversely, the integration of HIV into primary health care is carried out within the overall hospital outpatient departments and healthcare services (24). Comprehensive healthcare service delivery is delivered through these structures inclusive of treatment and care, preventive, promotive, and care of common problems. However, Masupe et al. have stressed that Botswana's health system is unlikely to successfully implement routine integrated HIV and NCDs management care unless its healthcare workers are knowledgeable and capacitated on combined NCD/HIV disease management models (25).

Although not part of the modern healthcare system, traditional health practitioners registered under the Medical, Dental, and Pharmacy Amendment Act of 1987 provide services, especially in rural areas (24). However, traditional doctors' roles in the response to NCDs is not well documented but unconfirmed reports indicate that NCDs patients, once they have lost confidence and hope in conventional biomedical methods, do consult with traditional doctors. Furthermore, the district level response is carried out by the DHMT which has been responsible for PHC since 2010, after the revitalization of PHC. The DHMT, as discussed in subsequent Chapters, is responsible for curative health care, and the local government ministry, through the District, is responsible for environmental health. HIV/AIDS and NCD preventive measures are the responsibility of district aids coordinators (DAC), carried out through a multisectoral approach by the District Multisectoral Aids Coordinating Committee (DMSAC), Chaired by the District Commissioner.

1.1.5 Conclusion and rationale for the study: gaps in knowledge and platforms for building a response to NCDs in Botswana

Non-communicable diseases (NCDs) account for 60% of global mortality and 38% nationally in Botswana. This section has summarized both global and Botswanan policy development initiatives and processes for NCDs. According to the literature from across sub-Saharan Africa (SSA), there is recognition of the growing burden of NCDs that calls for a substantial response. In Botswana, basic health system strengths, macro-economic conditions and relatively sound governance, alongside the successful implementation of HIV strategies and interventions, can be used as a platform to start the development of initiatives to provide prevention, care and treatment services for NCDs and other chronic conditions. The HIV/AIDS epidemic and the effective response to it, placed Botswana at

the centre of the worldwide fight against the disease (12), while Reid et al. suggested that Botswana can thus leverage its response on NCDs by learning from its response to HIV/AIDS (26).

However, although the magnitude of the NCD burden in Botswana is high and growing, responses to address the burden remain negligible in Botswana. Robust global policies and strategies developed to respond to NCDs have been developed, but little is known about Botswana's NCD response, the factors and challenges affecting this response, or the gaps remaining. The rationale for this PhD is, therefore, the need to develop more knowledge and understanding of policy development processes and responses to NCD prevention and control. Botswana is a useful case study to address this gap in knowledge because it is possible to examine whether actors have successfully leveraged learning and corresponding policy structures from the successful HIV response. The case study of Botswana can also be used to generate knowledge or policy themes that can be explored in other LMIC settings where government and other policy actors are seeking to develop policies to manage NCD burdens.

This thesis seeks to understand the extent to which the NCD response has been successful in Botswana and whether it has been able to build upon, and leverage, the successes and learning from the country's HIV response. The four NCDs on which the thesis focuses are: cardiovascular disease, diabetes, chronic respiratory disease, and cancer.

1.2 Aims, Objectives and Research Questions

1.2.1 Research Aims and Objectives

First, the aim of this PhD research is to explain the policy responses to NCDs, Cardiovascular, Diabetes, Chronic respiratory and Cancer and related risk factors, harmful use of alcohol and tobacco in Botswana, and their adequacy, in view of the growing NCD burden in Botswana. The PhD seeks to analyse the actors, contexts, and policy development processes underpinning the response to non-communicable disease in Botswana and examines the factors that have supported or obstructed this response. Second, the PhD aims to understand whether Botswana has successfully leveraged learning and corresponding policy structures from the HIV policy development response, in order to show how the NCD response can be strengthened. The thesis ends with the formulation of lessons for the future response to NCDs in sub-Saharan Africa.

1.2.2 Key Research Questions

There are four interrelated objectives to this study, each associated with a range of research questions that draw on the conceptual framework discussed in section 2.3 below:

1. To analyse the policy framework that underpins the development and implementation of the NCD policy response in Botswana.
    a. How have actors taken advantage of the policy window created by the UNGASS, WHO "Best Buys", and the Alcohol and Tobacco Policy to develop National Strategic Frameworks and other key policies?
    b. To what extent has policy development been aligned with political forces?
    c. How were different sectors involved in the design and development of the Botswana National Strategic Frameworks on NCDs and policies?
    d. What lessons can be drawn from HIV policy responses? How does HIV differ from NCDs? Where are the similarities? What are the challenges and opportunities?

2. To analyse the key guiding institutional actors active in NCD response.
    a. What are actor interests, interactions, actions or inactions to integrate NCD responses?
    b. What are the guiding institutions and processes through which they shape policy? What are their formal roles and responsibilities according to both their described official mandates and their actual incentives and actions?
    c. What lessons can be drawn from experiences with HIV and AIDS? (In terms of actors/guiding institutions involved, roles, processes, power etc.).
    d. Why is it that the MoHW does not have the same commitment in the response to NCDs as it did with HIV? Why is there a difference? To what extent has policy development been aligned with political forces?

3. To analyse the wider group of actors involved in NCD responses in Botswana.
    a. What are these actors' interests and interactions?

b. What different actors are involved in developing NCD policy (both for service delivery and prevention of risk factors)?
c. How are they involved in the policymaking or policy-(un)making process?
d. What are their commonalities and differences?
e. What is their source of power? What are the actors' roles and responsibilities in developing policy in response to NCDs and how do they coordinate?

4. To consider the difference in actors' perceptions of the HIV/AIDS policy responses and the NCD policy response in their context.
    a. How are national and international politics framed in relation to NCDs in Botswana? How did these relate to Botswana's development trajectory over time?
    b. What are policy stakeholders' perceptions and views towards NCDs and risk factors? What are their views towards the harmful use of alcohol and tobacco?
    c. What lessons can be drawn from the framing of HIV, that can be contextualised locally in the framing of NCDs? (e.g., global networks, cultural issues).
    d. How do the alcohol and tobacco industries frame NCDs in Botswana (nationally and internationally)?

1.3 Conceptual Frameworks

1.3.1 Shiffman and Smith's explanatory model

As noted in the literature review in Chapter 1, this research employs Shiffman and Smith's explanatory model (27) that offers a framework of analysis to understand why some global health initiatives are more successful in generating funding and political priority than others. The framework includes 11 factors in four broad domains that assess whether an issue will become a political priority [1] (see also **Annex D for an Illustration of the application of Shiffman and Smith's conceptual framework**). The four domains are actor power, ideas framing the problem, political contexts, and issue characteristics [1]. To assess Shiffman and Smith's domain on actor power, the PhD thesis looked at the factors shaping the country's policy priorities. This was carried out by conducting research

interviews with key actors to examine, first, actor interests or actions and the guiding institutions and their sources of power in the development of the NCD policy response. It specifically looked at the role they play and examined whether the Ministry of Health and Wellness has the same energy and drive in the response to NCDs as was the case in the response to HIV/AIDS. The research also examines how actors interact and work with other actors. The thesis looked at the strengths of the individuals and networks concerned. With regard to leadership, which formed part of the triangulation process, the thesis research looked at who is involved in key actor leadership roles, what activities do they carry out and how they interact with other actors. It also looked at the policy community and examined who is involved in the process of policy development and assessed whether the actors feel they can go alone in the process of policy making or not and also asked the questions as to what policy making entails and whether it is formal or informal. Finally, it also investigated the civic movement participation and asked questions as to whom with their movement is involved in the process of policy development, determine the extent and magnitude of social mobilization and make assessment of annual meetings.

In the Botswana example, the guiding institution in NCD response is the Ministry of State President, which works closely with the Ministry of Health and Wellness, and the Botswana National AIDS and Health Promotion Agency (NAHPA). The Ministry of State President is responsible for the coordinating role and has maintained the same multi-sectoral structure that was used in the response to HIV/AIDS and seeks to work closely with the community and industry. Previously the NCD unit was housed at the Ministry of Health, and it has since been moved to NAHPA which came as a result of the National Strategic Framework for NCDs 2018-2023.

According to the MoHW, UNDP and WHO Report, (28), the Alcohol and Substance Abuse Division stressed that it oversees the implementation of the National Alcohol Policy and drives the national alcohol response is over stretched and often cannot cope with the workload. The Report argues that It cannot be expected to drive a robust and effective national response to alcohol abuse. The division lacks the capacity, including personnel, to achieve its mandate. The intersectoral committee does not meet as regularly as it should, nor does it play a role effectively. The MoHW plays the role of the implementor as well as the coordinator. It coordinates its own activities and the activities of other parallel Ministries under the overall Strategic Framework of the National Alcohol Policy 2010. The coordinating role is done by NAHPA.

The second domain in Shiffman and Smith's framework looks at framing the problem. It is notable that only in 2016 did Botswana establish a National Strategic Framework on NCDs. The framing domain has internal and external frames. The former looks at the degree to which the policy community agrees on the definition of, causes of and solutions to the problems. External framing looks at public portrayals of the issue in ways that resonate with the external actors, especially the political leaders who control resources. During the interviews, the questions asked were whether the research participants think that they and the people they are working with understand what constitutes the problem and whether they agree that there is a problem? What are their perceptions of the problem? And lastly, research participants were asked to assess how people in the general public understand the problem.

The third domain is political context, which first looks at *policy windows*, the political moments when conditions align favourably for an issue, presenting opportunities for advocates to influence decision making and this looks at the global governance structure. It considers the degree to which norms and institutions operating in a sector provide a platform for effective collective action. The questions asked during research interviews were: Why are you doing this now? Are there any priorities? What is influencing their behaviour? What is the extent and participation of the donors? Are they coming with money? Are the donors exerting any pressure or not?

In the context of Botswana, the political moments that present opportunities to influence decision making in the response to NCDs and risk factors were created by the UNGASS 2011, WHO "Best Buys" Interventions, the Framework on Tobacco Control (FCTC) and the Global Policy on Harmful use of Alcohol, and the SDG 3.4. Although Botswana acknowledged that NCDs were the silent epidemic that needed to be addressed, the government only developed the National Strategic Framework on NCDs in 2016. Before this date, the only national policy instruments related to NCDs were the Alcohol Policy, Botswana Public Health Act, and the Essential Health Services Package – but these did not comprehensively address NCDs. The thesis examines whether there has been adequate political commitment and funding, as was the case with the HIV response, to take advantage of these policy windows.

The fourth domain of the Shiffman and Smith's framework is Issue Characteristics. It looks at *credible indicators*: the extent to which there are credible indicators that can be used to assess severity and monitor progress. The domain also looks at the *severity* of the

problem, for example acknowledgement that NCDs are the leading cause of morbidity and mortality. The third factor in this domain is *effective interventions*: What is being done to respond to NCDs? Are there any policies and strategic frameworks developed to address them? When were they established and is there funding for them? It also considers human resources and infrastructure availability, funding, for such interventions.

Data and studies on NCDs and risk factors in Botswana provide clear and credible indicators that there is a problem: NCDs and risk factors are the leading causes of morbidity and mortality in Botswana, accounting for 38% off deaths, (29), (10) and (30). The prevention and control of NCDs has been prioritized and included in high level national documents such as the 11th National Development Plan 2017-2023, Ministry of Health Wellness Strategy 2017-2023, and the National Essential Health Service Package. Before 2016, a national policy or strategy on NCDs was lacking. A successful response to the emerging NCD epidemic will require interventions as noted by (26) such as training of health workers to deliver high quality disease specific care. They observed that in Botswana the primary care response to NCDs is unstructured and inadequate.

Referring to the four domains, this research draws on several analytical strands to undertake an analysis of actors involved in NCD policy development relating to service delivery and risk factors, and to identify and describe the actors in the NCD response, their roles, power, and positionality. I also investigate how the issue of NCDs in Botswana was developed and framed, by exploring the actors involved and examining the specific activities related to ideas framing the issue of NCD and risk factor responses. I then sought to understand the political and policy context in which the actors operate, which has influenced decision-making in response to NCDs. Lastly, I investigated how issue characteristics, the ways in which NCDs are understood, the severity and prevalence of the issue, have affected the NCD response over time and have impacted policy development. To further understand these dimensions, I draw on other concepts, including policy windows and policy entrepreneurs by Kingdon and Stano [2], and Lukes' framework on power [1] (see sections 2.4 and 2.5 below).

The PhD will make an original contribution given the gap in scholarly work and understanding, demonstrated in the literature review, about responses to NCDs and risk factors. To date, there are limited studies which have paid attention to policy processes for responding to NCDs and their risk factors, including a lack of policy alignment and actor coordination. Health policy is a sub-set of public policy and can be understood as

the courses of action (and inaction) that affects the sets of institutions, organizations, services, and funding arrangements of the health system, Reader (31) and Sanni et al. (32) have highlighted that health policy determinants are the result of the outcomes of actions within and between sectors, at the global, national and sub-national levels that influence the socio-economic landscape of population's health and well-being.

To better understand NCD policy responses and risk factors in Botswana, Shiffman and Smith's framework was deemed most appropriate for this purpose and, as such, was selected for this study. But I also draw on concepts from other relevant frameworks. Shiffman and Smith's framework is deemed appropriate for this study because it aims to explore influences on priority setting. I also chose to use the Shiffman and Smith's framework instead of others since it offers a feasible approach to qualitative synthesis for health policy analysis research and offers huge value in guiding cross-national as well as cross-policy research and analysis in a field that has been neglected and underdeveloped, as observed by (33). Other related and similar frameworks were considered, although not used wholesale in this study, including Kingdon's multiple stream framework and Walt and Gilson's Policy Triangle. Their insights and limitations are briefly discussed below.

1.3.2 Kingdon's Multiple Stream framework

Kingdon's Multiple Stream Framework (MSF) is a well-respected approach for analysing policy making across various policies and countries. Kingdon's multiple streams framework is one of the most used conceptual tools for understanding the process of policy making, including policies in the field of healthcare (34). According to Behzadifar et al. (34), scholars use this framework to gain a fuller understanding of the policy-making processes, including how they are developed and implemented. According to Kingdon's model, public policy is made up of three independent streams: the problem stream, the policy stream and the politics stream (35). Mhazo et al. (36) also refer to these three streams developed in Kingdon's framework. Kingdon and Stano (35) and Snell et al. have also shared these same ideas (37).

The problem stream refers to the perception of problems as public matters requiring intervention (35). According to Behzadifar et al. (34), this stream includes issues that health policy decision makers, researchers, doctors, and other stakeholders can achieve in their daily routines, monitoring activities or scientific research. Behzadifar et al. (34) stressed that decision makers and policy makers can determine and evaluate different scenarios using evaluation tools and indicators, stressing that these indicators may relate

to, among other things, personnel shortages, pandemic and disease outbreaks, road accidents, and increased health care costs.

The second of Kingdon's streams is the policy stream. According to Behzadifar et al. (34) and Kingdon and Stano (35), the policy stream involves potential solutions to the problem and allows individuals and groups to work on a solution to develop it further. According to Benzadifar et al. (34), actors involved in this process can include non-state actors such as academics, lawyers and law makers, professionals, special interest groups, industry researchers, and policy entrepreneurs. According to Mhazo et al. (36), these people or groups can influence agenda setting through their inputs and interventions.

The final stream in Kingdon's model is the politics stream. The politics stream comprises political actors, events or related contexts such as swings in national mood, changes in government and campaigns by interest groups, interest group advocacy campaigns, and elections (34). In addition, Benhzadifar et al. stressed that pollical party representatives, parliament members, and the bureaucracy may also play a prominent role in influencing the political process (34). Kingdon's model also recognizes the role of policy 'entrepreneurs', who take advantage of agenda-setting opportunities, known as policy windows, to move items onto the formal agenda (35). According to Kingdon and Stano (35), these policy entrepreneurs can be visible or 'hidden'. Visible participants, according to Benzadifar et al. (34), are organized interest groups that focus on policy debates or discussion about specific problems, while hidden participants are more likely to be specialists in the field, researchers, academics, and consultants who work predominantly in the policy stream to develop and propose options for consideration.

Limitations of the Kingdon Model

Cairney and Jones (38) describe this approach as being helpful for conducting case studies, and has had extensive impact, helping scholars in an era of policy process conceptualizations, with a 'universally applicable' approach. However, Hoefer (39) argues that Kingdon's multiple stream framework's major limitation is its ambiguity in relation to problem definition, in that different actors define the same situation differently, so maximal clarification or definition of the goal is very difficult. The final assumption in the MSF is that independent processes occur when policy decisions are made. The other limitation of the MSF is its assumption that policy problems, policy solutions, and political conditions are constant; however, these processes or contexts shift constantly and without clear linkages to each other (39). Furthermore, what is viewed as a problem by

the policy community, which is usually composed of government actors, interest groups, academics and others, may be viewed differently by "policy entrepreneurs" (39). These people want government to pay attention and do something about the problem as they define it, but they do not necessarily have a particular way to solve the problem in mind (39). Moreover, within the policy solutions stream, think tanks and academia play a key role in developing policy ideas, but not all policy ideas have equal chances of being accepted (39). Furthermore, Hoefer (39) indicated that some of the ideas are not adopted primarily because some are seen as too expensive, others lack feasibility, while others go beyond the limits of acceptable policy in any given context.

In my study I draw on various aspects of Kingdon's model, including the window of opportunity (created internationally for NCDs) and how the three streams shaped actor response to NCDs in Botswana.

1.3.3 Walt and Gilson's Health Policy Triangle

Other policy analysis frameworks used in health policy development include the framework developed by (33). The policy analysis triangle has process, content, and context dimensions, and actors are at the centre of this framework. The framework shows how these four elements interact in shaping and implementing a policy (33). Khodayari et al (40) define actors in the policy development process as a set of individuals, groups, and organizations involved in or influenced by the implementation process. Furthermore, Buse (41) referred to processes as all actions and activities performed during policy implementation. Policy content refers to the details of the policy itself, and Khodayari et al. (40) referred to content as a set of goals and planned actions that bring the policy to fruition. Context refers to a set of global and national geopolitical and socioeconomic factors that influence health policy processes and actors (40).

Walt and Gilson's policy analysis triangle framework was used to analyse the policy-making process in the prevention and control of cardio-vascular disease (CVD) in Iran at the secondary and primary prevention levels, (33). The results of this study were presented in accordance with the triangle of policy analysis in the four main dimensions of this framework (i.e., actors, content, context, and process) in Khodayari et al. (40). The policy context according to this study included political, administrative, financial, social, and cultural factors. The content of the policy in a CVD study in Iran included a set of goals and actions planned in global and national prevention plans Khodayari et al. (40). International documents were utilized to guide national-level government responses to

prevent and control CVD, and to create and strengthen health systems, (40). The study findings, according to Nugent et al. (42), showed that CVD prevention and control received limited policy attention. Actors in this study referred to the guiding institutions acting as stewards and how they coordinated the CVD response by engaging with stakeholders. The stakeholders adopted a multi-sectoral approach and included other ministries. There is also a national committee for the Prevention and Control of NCDs and Risk Factors in Iran. Lastly, the process referred to the establishment of the National Committee for the Prevention and Control of NCDs, formed with a focus on discussing NCDs to prevent and control these diseases and associated risk factors [1].

The policy triangle was particularly used to inform my analysis of actors – and how they interact with context and process in the case of NCD response in Botswana.

1.3.4 Dolowitz and Marsh's policy transfer framework.

The other useful framework for my thesis was Dolowitz and Marsh's [(43) *policy transfer framework*. Dolowitz and Marsh defined policy transfer as the process in which knowledge about policies, administrative arrangements, and institutions in one time or place is used in the development of policies, administrative arrangements, and institutions in another time or place (43). There are other terms that are used and are related to policy transfer, including lesson learning, as identified by Rose (44). Policy transfer, lesson drawing, and policy convergence assist in understanding the adoptability and adaptability of policies in different settings and I draw on this in my analysis of NCD policy response in Botswana.

1.3.5 Concluding remarks about conceptual frameworks

The section discussed various conceptual frameworks that were considered and informed my study. Shiffman and Smith's framework was considered to be the most appropriate and important framework to inform this PhD's data collection and analysis. However, other frameworks were drawn on: Kingdon's multiple streams framework, Walt and Gilson's policy analysis triangle and Dolowitz and Marsh's policy transfer framework.

1.4 Case Study Approach

This thesis represents an exploratory case study of NCD policy in Botswana, using a policy analysis approach, as described in detail in Chapter 3 (Methods). A case study is a research method used to investigate an individual, a group of people, or a particular phenomenon,

(45). Yin and others define the case study research method "as an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (46). It is often focused on a small geographical area or on a group of individuals with specific characteristics (46). In the area of health policy analysis, case studies typically involve careful and comprehensive qualitative analysis of a case such as a policy and a set of health systems structures (45). Case studies may involve a range of methods – qualitative methods such as interviews, observation, documentary analysis, and also quantitative methods such as surveys and use of secondary data sources such as routine statistics (46, 47). Solberg and Hubert state that case studies can be used for both descriptive and empirical research, and when used in descriptive research the case study describes a situation that we have observed or have been told about by research participants (48).

Case studies can generate qualitative data that are rich and authentic (49). As such, they provide an opportunity for the researcher to gain an in-depth holistic view of the reality, and may help to describe, understand and explain a multifaceted research problem or situation (50). Zainal argues that one of the reasons for the increasing use of case studies in health systems research is that researchers were becoming concerned about the limitations of quantitative methods in providing holistic and in-depth explanations of the social and behavioural problems that are being studied (51). Tellis and other authors noted that case studies may interweave both quantitative and qualitative data to explain both the nature of the phenomena and the social processes involved (50, 52).

For my PhD, I chose a case study approach as particularly well-suited to an in-depth exploration of the NCD policy response in Botswana. It enabled me to examine this topic in view of the historical as well as the political contextual factors that shaped and explained the policy development response (or lack thereof) to NCDs and their risk factors in Botswana. Qualitative research often starts with the assumption that social reality is a human creation, and data can be interpreted and contextualised through the lens of people's beliefs and practices (53). This methodology is constructive or interpretive, aiming to unveil the "what," "why," "when," "where," "who," and "how" (or the "5W1H") behind social behaviours and interactions, rather than merely quantifying occurrences (53). My PhD case study focuses on the country's response to NCDs and their risk factors, helping to understand the problem of a lack of clear leadership, vision or plans for an effective NCD response in the country. It enabled me to explore how respondents compared and contrasted the country's NCD response and its response to HIV/AIDS, and

to identify gaps in the current NCD response and the need for the repurposing of existing structures.

While I had to change my study methodology due to COVID-19 and the travel ban and restrictions, I was able to collect rich data as the respondents were eager to share their experiences and knowledge during data collection (see Chapter 3 Methods). The case study methodology involved applying a range of techniques, including two types of literature review (a scholarly article review (Chapter 2) and a review of policy documents (Chapter 4)) and semi-structured interviews. Given that data were sparse, this allowed for triangulation of the findings from each method and analysis of their findings as a coherent 'case' (the development of NCD policy in Botswana).

1.4.1 Strengths and shortcomings of case study methodology

As a research methodology, the case study is frequently used to expand our knowledge of individuals and groups, and organisational, social, political and other phenomena. My PhD case study research elicited the perceptions of key stakeholders and how different organisations, groups and individuals framed the problem of NCD policy response, and rooted this in the political and social landscape of Botswana.

Various advantages of case studies have been presented by researchers. For instance, Cronin states that the case study is a highly legitimate research method appropriate for qualitative research (54). Whilst Flyvbjerg emphasises that case studies can elicit real life situations and test views in relation to a phenomena (45). Zainal notes that researchers can adopt either a single-case or multiple-case design depending on the issue in question (51), but notes that the drawback of a single-case design is its inability to draw generalisable conclusions, in particular when the events are rare (51).

Much of the methodological criticism directed towards case studies is that they are unable to provide insights into causality or elicit general findings (as opposed to specific findings in specific conditions) (55). Stake (56) argues that the biggest concern is the lack of scientific generalization possible from a case study because it relates only to a particular context or few units. Jacobsen (57) and Yin (46) also question whether it is possible to generalise from the result of the case study findings. Nevertheless, Zainal suggests that the problems associated with a single-case design can be overcome by using multiple methods for a case study and triangulating the case study findings with those generated through other methods in order to confirm the validity of the findings

(51). Thus, my study utilises both a policy document review (Chapter 4) and primary interview data to validate and enrich the Botswana case study findings.

Other criticisms of the case study approach relate to the nature of the work involved, noting that collecting and analysing data is a highly labour intensive activity that may be problematic even for skilled researchers who may have limited time or resources (58). Cope stresses that case study research, although often described as flexible, is a rather undefined and challenging methodology (59). Even though case studies are common, according to Merriam, there is still a lack of clarity and no real consensus on what a case study is, what the practical steps in conducting that form of research are, and what results can be obtained from it (58). Yin however, notes that case studies have both advantages and disadvantages as a research method, and that it is important to acknowledge that fact and have strategies addressing the challenges (46). Whether or not to choose a case study or some other approach depends on what it is that the researcher is looking for and what questions the researcher wants to answer (46). The merits of a particular method depend on whether it is the most appropriate way of addressing the research problem (60).

Some researchers argue that the commonly stated disadvantages of case studies are in fact not always significant. For instance, even though case studies have been criticised for their narrow focus and small sample size, Siggel argues that this is not necessarily an issue and sometimes one case is sufficient to provide a powerful illustration and understanding of a particular phenomenon (61). Furthermore, the question of whether or not case study research can produce valid generalizations is a question that has been disputed. Hammersley argues that the objective of case study research is not to generalise findings but to prove, test or develop theory (62). Thus despite some if its limitations, the case study method can be used successfully in carefully planned studies of real life situations, issues and problems (63).

1.4.2 Why I chose a case study approach

Considering the advantages and critiques associated with the use of the case study approach, I selected it as the most appropriate for my study to assist in answering my research questions and supporting data analysis. My case study approach provides in-depth understanding and analysis of the complexities of policy implementation, and the perspectives of a diverse range of stakeholders engaged in action and/or inaction. This methodology helped in testing established theory, and in this study, I applied the

Shiffman and Smith policy analysis framework in a flexible manner to conduct in-depth analysis of the policy response and development to the rising burden of NCDs and its risk factors, including tobacco use and harmful use of alcohol in Botswana. This framework assisted in the framing of the issue as well the development of the study guide (see the academic literature review in Chapter 2, and Chapter 3 on methods).

1.5 Structure of the Thesis

In this first chapter I have described the background, context and rationale to the PhD thesis, its aims and objectives, its conceptual framework and methodological approach. I discussed in detail the UN Political Declaration on NCDs in 2011 as well as the policy window set by the WHO "Best Buys" considered for adoption and adaptation by member states. Furthermore, relevant history and context for the Botswana case study are discussed. This describes the overall country context in its response to NCDs and compares this to the HIV/AIDS response, examining how this could be built on and leveraged for the NCD response. The section looked at Botswana's health care system, and makes a comparison with other country case studies from sub-Saharan Africa and how they responded to NCDs and risk factors, leading to a concluding statement of the problem, research gap and rationale for the research. I then described the aims and objectives of the thesis, followed by the conceptual framework used by the thesis and which guided data collection and analysis. The reasons for using a case study approach are then discussed.

Chapter 2 presents a narrative literature review relating to the thesis. It describes NCD policy development processes in sub-Saharan Africa and in Botswana, applying the conceptual framework of Shiffman and Smith. It also examines the experiences of translating the UN Political Declaration on NCDs 2011, as well as the WHO "Best Buys" 2013-2020, to national policies for the prevention and control of NCDs.

Chapter 3 details the thesis' methodological approach and the methods of data collection, organization, and analysis. Ethical considerations, risks, and risk mitigation are described, as well as a discussion of limitations and quality assurance considerations.

Chapter 4 presents a second review of literature, this time focused on the policy documents at global and national level in Botswana which are designed to instigate, inform and support NCDs responses. The review examines their origins, scope and limitations. It reviews the main policies and critiques of each (e.g., what is missing, what

seems comprehensive, what is unclear, are they useful/good documents (e.g., compared to WHO Best Buys or recommended policies)) and identifies gaps.

Chapters 5 and 6 then present and analyse the findings from the interview data. Chapter 5 analyses the key actors and guiding institutions in NCD policy in Botswana. It describes the actors: who they are; their mandates, roles and responsibilities; and how they network across different levels, including how they relate to other actors. The chapter discusses leadership, issue characteristics, fragmentation, lack of cohesion (between actor statements/goals/prioritisation), and lack of funding, for example.

Chapter 6 analyses other policy relevant actors and their actions: industry (for profit/others); civil society; youth; foreign research groups; and donors. This chapter also discusses the relationships between these civil society actors and government actors and how they relate to or conflict with each other. Finally, Chapter 7 presents a discussion of the findings and the main recommendations that emerge from them, and compares the study findings (discussed in Chapters 4, 5 and 6) with wider literature. The discussion chapter also reflects on why NCD policy development and implementation differ so much from the response to HIV/AIDS.

Chapter 2: Review of Literature on NCD Policy Responses in Sub-Saharan Africa

2.1 Methods

This chapter provides an analysis of NCD policy in Botswana which, where relevant, draws parallels and lessons from the HIV response. A literature search was conducted to determine the experiences of translating the 2011 UNGASS Political Declaration on Prevention and Control of NCDs into national policies in sub-Saharan Africa. The search also aimed to determine experiences of operationalizing WHO "Best Buys" interventions at national level, for example evidence on the extent of applications made, of multi-sectoral action on NCDs (focusing specifically on cardiovascular diseases, diabetes, chronic respiratory disease and cancer), and on prevention and control of risk factors (harmful use of tobacco and alcohol).

The literature search was undertaken using PubMed and Google Scholar databases, covered the period from 2010-2020, and included both peer-reviewed sources and grey literature / policy documents relating to Botswana and sub-Saharan Africa. The key search terms used to identify the literature were 'non-communicable diseases', 'policies', 'health systems', and 'Africa'. In total, 44 papers met the inclusion criteria for the initial review of the literature. The inclusion criteria were: studies that focused on policies related to NCDs and risk factors that could be developed and implemented at the international, regional and national level; and second, studies that focused attention on policy development responses to NCDs and risk factors.

I excluded reviews and studies that did not address and provide detailed analysis on NCDs and policy development responses. Furthermore, studies that were biased and not founded on empirical evidence and or theoretical accounts of NCDs and risk factors were excluded. Data extraction of the literature included, author, year, policy target and content.

Some of the policy documents identified are also used in the review presented in this chapter. But the main analysis of relevant policy documents is conducted in more detail in a structured policy document review in Chapter 4, as part of the overall primary data analysis for understanding NCD responses in Botswana.

Data were extracted after review of the titles of the papers, the approaches, methods, findings, the framework that was used, and key words (see **Annex A:** The process of selecting the articles). A sample of the selected papers from the data extraction table are shown in **Annex B** (Annex B: Data extraction table). **Annex C** provides a summary of the key findings from the exploratory review in relation to the framework dimensions of interest to this PhD. The initial scoping review informed the background and rationale for the research, helped formulate the research aims and questions, and defined the study design and methods.

Abrami et al. offered an operational definition of the criteria used for including and excluding studies (64). According to Abrami et al. the eligibility criteria are liberally applied in the beginning to ensure that relevant studies are included, and no study is excluded without thorough evaluation (64). At the outset, studies are only excluded if they clearly meet one or more of the exclusion criteria. According to Melini et al. the choice of inclusion and exclusion criteria should logically follow from the review question and should be straightforward (65). The selection process determines the scope and validity of the systematic reviewers' conclusions. Studies are typically excluded from the pool of studies because they clearly meet one or more of the exclusion criteria, include incomplete or ambiguous methods, fail to meet a predetermined threshold for quality, or fail to report sufficient statistics or data for estimating effect sizes (65).

Robey and Dalebout stressed that prospective studies for systematic reviews are evaluated for eligibility on the basis of relevance and acceptability (66). According to Robey and Dalebout, systematic reviewers ask: Is the study relevant to the review's purpose? Is the study acceptable for review? Systematic reviewers then formulate inclusion and exclusion criteria to answer these questions (66). Each systematic review has its own purpose and questions, so its inclusion and exclusion criteria are unique (66).

2.2 Analytical framework for the review: NCD policy responses and processes in sub-Saharan Africa

Although the UNGASS 2011 (1) and WHO 2013-2020 Global Action Plan (67) place much emphasis on stakeholder engagement and the utilization of a multi-sectoral approach (MSA), there have been differences in how these were applied in different countries, as well as challenges evident in the response to NCDs in sub-Saharan Africa. Shiroya et al. (68) reported that country-level policy development has been relatively slow and uneven,

illustrating the example of policy processes for tobacco, which moved faster in South Africa but were delayed in other study countries. Shiroya et al.'s (68) submissions are supported by Walbeek, stressing that South Africa's experience in tobacco control provides some important lessons for other countries (69). Walbeek stresses that, firstly, strong and consistent lobbying was required to persuade the government of South Africa to implement an effective tobacco control strategy (69). Country-specific research, drawn from a variety of disciplines, was used to back up and give credibility to the lobbyists' appeals. Secondly, Walbeek states that rapid increases in excise taxes on cigarettes are particularly effective in reducing tobacco consumption (69). For their part Juma et al. (25) acknowledged some degree of application of multisectoral approach MSA in NCD prevention policy in the countries studied and provided an example of tobacco and alcohol policies. Furthermore, Juma et al. (25) also described how sector engagement varies across different NCD policies, from passive participation to active engagement, although with no detailed analysis as to why this was the case. The reasons for passive participation may have been that the various sectors may not have been aware of their potential contribution, there was weak political will, ensuing coordination complexity, and inadequate resources [6].

The authors found that although alcohol policy development has been slow in Nigeria and Malawi, the process for developing the tobacco policy moved faster in South Africa. Essue et al. (70) argue that despite NCDs being a health priority, priority setting was not entirely successful due to insufficient resources and inconsistent involvement of stakeholders, with Wickramasinghe et al. (71) citing cultural and bureaucratic challenges as the major constraints. Lupafya et al. (72) highlighted differences across countries' responses to NCDs, in terms of the integration of NCD health services within existing infrastructure, capacity building, innovative funding solutions, and greater implementation of planned activities. Other challenges include inadequate resources, such as financial capital, human resources, equipment, supplies, and transportation.

There are clear differences in the integration of NCDs health services into existing infrastructure in the country's response. To analyse these differences, I employed Shiffman and Smith's framework (27) (discussed further in Chapter 2) to focus on global health issues. The framework comprises four broad categories: actor power, ideas framing the problem, political contexts, and issue characteristics (27). Further, the framework has a total of 11 factors, each of which has corresponding factors that assess whether an issue

will become a political priority. A summary of the literature review findings, organized according to this framework, is discussed below and details are presented in **Annex C: Summary of the literature review findings**. For further details about Shiffman and Smith's policy analysis framework, see **Annex D: Illustration of the application of Shiffman and Smith's conceptual framework.**

2.3 Review findings

1. Actor Power

The first domain in Shiffman and Smith's conceptual framework (27) refers to the influence of organizations and individuals involved in the policy process (actors), the existence of a policy community, and respected leaders. Actor power is conceptualized in relation to three components: cohesive leadership, a guiding institution, and the mobilization of civil society through networks and advocates to advocate at national and international levels (27). This section identifies the key actors involved in relation to the actor power domain, as well as their power and interconnections (e.g., how they coordinated and worked together). Although not explicit in the framework, the role of the private sector (industry) is also discussed because of its significance in NCD policy planning, formulation, and implementation. The number of key actors involved in the response to NCDs and related risk factors in different country settings suggests that the issue is gaining traction, despite the prevalence of some positive and negative connotations. The different study countries in the NCD and risk factor responses show some commonalities with respect to key actors, their roles, and how they are coordinated. According to the literature, the response to NCDs and risk factors in sub-Saharan Africa involves a range of actors from global to national and sub-national levels. Several groups of actors emerge as key in NCD policy development: government/guiding institution, civil society, industry, and leadership. This section will consider each in turn.

Government: cohesive leadership and a guiding institution

A range of key themes have emerged in the literature in relation to the role of government. Studies from the literature show that while a variety of actors are involved in the response to NCDs and risk factors, the national government through the Ministry of Health plays a dominant role. Other government ministries such as education, communication or social welfare can play more minor roles. The global declarations and WHO Action Plans were not adopted in whole, in that although the global declarations provided guidelines as to who must be involved, how, and what mechanisms should be

used for the roll out from national level to sub-national level, there were national-level discrepancies (68). (73) stated that more than half of the African countries did not achieve the set target for 2015, which required more effort and commitment from the government and society to implement the set goals and targets for NCD and risk factor responses.

According to the literature, a national-level policy agenda led by the central government through the Ministry of Health in response to NCDs and risk factors was expected to be prioritized by following the global level action plans and the declarations recommended for implementation. However, there were clear problems of coordination by the central government, as identified in different country studies. Juma et al. (74) show that the application of coordinating mechanisms in NCD prevention policy development in their study countries varied across different NCD policies, from passive participation to active engagement and by country, as in Kenya, South Africa, Cameroon, Nigeria, and Malawi. In contrast, Wickramasinghe et al. (71) indicate that the pressure, competing priorities for sectors and perceptions that health issues were the preserve and responsibility of the health sector alone, together with bureaucratic and cultural barriers, acted as an impediment to foster collaboration in NCD and risk factor policy development in the study countries**.**

In summary there is growing evidence shown in the literature that NCDs and risk factors are gaining traction in sub-Saharan Africa. The central government, through the Ministry of Health, plays a major role in the development of national strategies and policies as well as a coordinating role in the response to NCDs and harmful use of alcohol and tobacco risk factors. The different countries studied clearly show evidence of non-compliance with global action plans, declarations, and treaties.

How do actors coordinate and work together? Policy community cohesion

Studies from different countries provide detailed insights into how responses to NCDs and risk factors are coordinated as well as their limitations. According to the literature, in various countries the central government, through the Ministry of Health, played a key coordinating role in the response to NCDs and risk factors guided by the WHO Global Action Pan 2013-2020 and NCDs strategic plans (6). WHO Global Action Plans also provide detailed guidelines and frameworks for the plan of action, as well as how coordination is to be conducted and who must be involved and participate. There have been many discrepancies with adherence to these demands and declarations. For example, a Multi-sectoral Approach/Action is recommended as a coordinating framework tool for adoption by different implementing countries in sub-Saharan Africa. Nonetheless, different country studies show that these were not fully utilized and hence could not be adopted (75). Mwagomba et al (76) indicate that the government played a major role in coordinating the involvement of all key stakeholders by using policy documents, however, there were challenges as coordination was only the preserve of experts or technical groups (77). These coordination mishaps also showed weakness in priority setting by the coordinating institution, thereby affecting the decision-making process (14).

Sanni et al. (32) described the importance of stakeholder participation in Kenya for diabetes and stated that the coordinating institutions worked closely with communities to respond to NCDs and risk factors, and that this was done through the support of policy leaders. However, the review findings show that although an opportunity for a policy window was set in which the different actors had to engage with the different stakeholders, it failed. In different countries, the literature indicates that a lack of political commitment affects coordination. Tassou et al. (78) reiterated this weakness in coordination and indicated that the level of coordination and implementation varied from one policy to another and from one region to the other. Sanni et al. (32) and Daivadam et al. (79) provide contrasting views on how actors coordinate and work with other sectors. The former indicates that a rigorous process of political mapping to identify the stakeholders' interests and their interaction with health and others was carried out, resulting in policy planning development, policy planning, strategies, formulation, and implementation that identified well with the interests of the stakeholders. The latter states that communication and active participation of stakeholders was undertaken. Nyaaba et al. (73) and Schwartz et al. (80) argue that coordination can be achieved

through various structures, and through public awareness campaigns, civil society collaboration, and community mobilization.

It is important to note that the policy outcomes arising from the coordinating mechanisms for NCD response from the different country studies do not show any significant success, but rather the challenges are more prominent. For example, in the Kenya diabetes study, although it found active participation of the diabetes lobby group, there was also acknowledgement that community participation was limited [6]. In the case of Botswana, according to the UNDP and BIDPA (2017), the Ministerial Committee was responsible for overseeing the implementation of the alcohol levy, and the department responsible for providing a coordinating role at the Ministry of Health was short-staffed and could not execute its functions clearly (28). There is little detailed analysis provided in the literature as to why there is such a mismatch in policy development outcomes for those driven by the government, compared to those driven by civil society, and other stakeholders.

Shiffman and Smith's framework does not discuss the role of the private sector, but the private sector's involvement in the response to NCDs and risk factors in the different countries in sub-Saharan Africa is worthy of discussion in the domain of actor power. The literature discusses the private sector from the context of alcohol and tobacco industry players, but does not specify how they have managed to shape the policy development response to NCDs and risk factors in the different study countries. The framework does not provide detailed guidelines on the role the private sector may play but includes them as part of a wider community of policy community networks. Engaging with the private sector has therefore become increasingly important, taking cognizance of this fact is that the UNGASS 2011 and the WHO "Best Buys" interventions have called for the private sector to participate in the promotion of healthy workplaces and improve affordability and access to medicine (1), (75). Some studies highlight the minimal participation of the private sector in addressing NCDs and risk factors, despite global recommendations, partly due to governments not involving private sector actors. For instance, in Botswana, the government demonstrated some commitment to addressing problems related to the harmful use of alcohol, but the alcohol industry was not consulted when the national alcohol levy was introduced. The government has put in place a number of legal, policy, and programmatic measures to control alcohol-related harm. The grey literature cites a draconian approach in the Botswana's policy response to the harmful use of alcohol in the country (81), (67). According to the Weekend Post and Liberty Africa newspaper

articles, BIDPA, and UNDP reports, it is suggested that the industry was not consulted when the alcohol levy was introduced, and that it was a unilateral decision that came as a result of a directive from the former President of the Republic of Botswana, LFT General Ian Khama. The reports also showed that the alcohol policy did not achieve its intended objectives and had spillover effects as more people resorted to binge drinking.

Shiroya et al. (68) also acknowledge the non-participation of the private sector and show how the 'non-health' sector remains largely uninvolved, contrary to global recommendations. Juma et al. (25) noted that while there was a strong engagement by the tobacco industry in developing tobacco regulation policies across countries (Kenya, South Africa, Cameroon, Nigeria, and Malawi), this was not the case with alcohol policies. While Juma et al. (25) highlight the high engagement of the alcohol industry in South Africa, they also refer to major policy development barriers, including weak political will, coordination complexities, and inadequate resources. There is no detailed analysis provided in the literature regarding disparities in engagement levels between the alcohol and tobacco sectors, and whether the tobacco industry was more aggressive in lobbying than the alcohol industry. Additionally, Essue et al. (70) cite weakness in priority setting, weak institutions, and insufficient mechanisms to ensure accountability for decision-making as a primary reason for the non-involvement of the industry and other stakeholders.

It is evident from the literature that the private sector appears to have a positive role to play, and global action plans provide ideas or opportunities for its involvement have been provided. While these global action plans, treaties, and WHO "Best Buys" Interventions provide directions for implementation, there seems to be a mismatch between what is prescribed at the global level and implementation or adoption at the national level. There also seem to be challenges with regard to private sector involvement and a lack of clarity about their role, as witnessed in Botswana and other country studies.

Civil society mobilization

The role and participation of civil society actors in the response to NCDs and risk factors is shown to be limited in the sub-Saharan Africa studies reviewed. The literature shows minimal participation of civil society apart from the Kenyan study on diabetes, where the Kenyan diabetes group played a successful advocacy role (68). This limited participation is contrary to the UN Political Declaration on NCDs, which highlights the critical role that civil society plays in the prevention and control of NCDs and their risk factors. UNGASS

2011 pushed for fostering partnerships between government and civil society, though there is scant evidence from the literature that shows the extent and magnitude of such partnerships in different country studies.

There is growing evidence that shows the role that civil society could play, ranging from technical support to advocacy, implementation, and monitoring, although in some study countries, they were not involved, and there is very little detailed analysis as to why this was the case. The active participation of the Kenyan diabetes interest group to trigger a political drive against prevailing challenges was an exception among the other country studies that showed little or no participation (68), but there is little detailed analysis of why this was the case. Nyaaba et al. (73), and (49) recognize the need for active involvement by civil society actors and state that the African Union (AU) and sub-regional bodies could generate knowledge through collaborative means, driven by policy makers, for a meaningful change in the response to policy development for NCDs and risk factors.

Additionally, Juma et al. (25) indicate that national-level policy development across countries has been relatively slow and uneven, and that the policy process for tobacco has moved faster, especially in South Africa, but has been delayed in other study countries, while alcohol policy processes have been slow in Nigeria and Malawi. NCD and risk factor policy development in the study countries reveal further that the mobilization of stakeholders and civil society was also minimal and mixed. Therefore, evidence about civil society stakeholder participation, engagement or involvement is limited, although mixed.

In summary, the papers provide insufficient assessment of the reasons for the lack of civil society action despite the recommendations by the UN Political Declaration on NCDs that acknowledge its key roles, from generating evidence to advocating policies and providing technical support.

Leadership and political commitment

In this section, I discuss the roles of leadership and political commitment, which are key to Shiffman and Smith's framework (27), and recognize the influence of cohesive leadership. It is evident from the literature that too much reliance on the central government through the Ministry of Health has not driven the political commitment needed for responses to NCDs and risk factors. This argument has been supported by various countries in sub-Saharan Africa, for instance, Ghana (4) and Tanzania (3). The former study argues that in Ghana there was little political interest, low community

awareness, and inefficient programme management, while the latter study in Tanzania points out a chaotic approach, with a lack of direction and coordination of the NCD response. Lupfya et al. (72) support this argument and blame the power imbalances that existed, as well as too much top-down control without providing the necessary platform to the community to be involved in the policy development space. This view is also shared by (76) in that the government exerted influence in serving as a key figure in coordinating roles. Sanni et al. (32) claimed that the coordinating institutions supported by the leadership worked closely together with the involvement of the community, although there is no such evidence.

In summary, although the UNGASS 2011 and WHO Global Action Plans 2013-2020 provided a policy window, there has been a mismatch in utilizing the recommended declarations and treaties. Different countries mostly attribute these problems to weak health systems and institutions, weak or no priority setting, lack of financial resources, and lack of political commitment.

2. Ideas Framing the Issue

This section focuses on the framing of the problem and policy response issue, that is, the framing of NCD and risk factors. Shiffman and Smith (27) emphasize the importance of framing, stating that an issue can be framed in several ways and that the different frames appeal to different audiences, with some frames resonating more than others. Internal and external factors are viewed as important in such framing, where collective action and the identification of ideas are key.

Internal framing

According to Shiffman and Smith (27), internal framing is different from external framing in that the former focuses on the causes and solutions to the problem as well as the agreement between the actors, while the latter looks at those in power and in the way the issue is portrayed. In several African countries, literature indicates that the promotion and framing of a common construct has not been difficult in response to NCDs and risk factors. There is a wider acknowledgement within the policy community linked to NCDs and risk factors that the harmful use of alcohol and tobacco are the leading causes of morbidity and mortality in sub-Saharan Africa, and that that calls for a deliberate policy response. However, the greatest challenges have been priority setting, stakeholder involvement, and financial and political commitment (4), (3).

More broadly, complex issues related to the internal and external factors affecting responses to NCDs and risk factors can be identified in SSA. These interrogations are necessary to assess the factors contributing to the national policy leaders' lack of political commitment and failures to utilize the external global declarations, or consider what is needed to narrow the response to suit national needs (15), (82), (78). Shiroya et al. (68) shared the view that national policy documents had translated the UN Declaration to national policies and strategies, and these aligned strongly with international documents, but importantly that there was scant local evidence on implementation. Similarly, Mwagomba et al. (19) point out that the WHO "Best Buys" interventions were not adopted in full in Nigeria, where only three of the twelve policy documents about "best buys" interventions were utilized. They also highlight the high turnover of personnel in different government departments, financial constraints, and role confusion between sectors. There is little detailed analysis in the literature explaining the reasons for localized framing, but some country studies state that this process was dominated by expert advisers and technical working groups (3).

External framing

It is important to note that the literature from different countries does not directly indicate how NCD and risk factor issues have been framed. However, overarching emerging issues are due to different governance, economic, and social justice factors. This was the case in Kenya, where according to Shiroya et al. (68), the national strategies aligned strongly with the international documents and lobbying by the diabetes interest group led to the government having a more committed response, although there was minimal local evidence to support this claim. This was also the case in Cameroon where it is stated that policy formulation was driven by the social contexts of NCDs and globally by the adoption of the WHO Framework Convention on Tobacco Control (78). They are also premised on inter-sectoral governance and economic factors. Different country studies show that the intersectoral and governance factors influence national, sub-national, and global factors on priority setting on NCDs and risk factor responses. Studies also show that governments, through the ministries of health, played a major coordinating role in their response to NCDs and risk factors, albeit with some challenges, such as not being able to follow the prescribed global recommendations and declarations. According to different country studies, the emerging overarching issues are a result of the unsuccessful implementation process, which was caused by weakness in priority-setting institutions despite NCDs being a priority area [3]. In addition, Juma et al.

(83) also cite economic reasons such as insufficient financial resources as factors contributing to ineffective response.

In conclusion, although data from sub-Saharan Africa show NCDs are the leading cause of mortality and morbidity, and there has been a steep increase in the use of alcohol and tobacco, there are NCD policy challenges related to implementation gaps and the lack of political commitment. The review shows that studies from different countries do not directly indicate how the issues are framed.

3. Political Context

This section examines the political moments that present opportunities to influence decision-making processes in response to NCDs and risk factors, in line with Shiffman and Smith's framework (27). According to Shiffman and Smith, political context refers to the environment in which the actors operate; it includes the ability of global actors to take advantage of policy windows to influence decision makers. This domain overlaps and shares more commonalities with actors' power and networks, and demonstrates how the actions that have to be undertaken by the actors are circumscribed by context.

Policy windows

Shiffman and Smith.(27) argue that one route to gaining political priority is to take advantage of the policy window, that is, the political moments that present opportunities to influence decision making. The United Nations High Level Meeting on NCDs, the WHO "Best Buys", the Framework Convention on Tobacco Control (WFCTC), the Global Alcohol Policy, and the Sustainable Development Goals (SDG 3.4) represent such policy windows. The UN Declaration on NCDs to national policies, strategies, and documents was expected to be strongly aligned with international documents. The national NCD and risk factor responses have thus become prominent as a result of the WHO "Best Buys" and the UNGASS 2011 Political Declaration that established trends towards more common adaptive global action strategies that called for the joint engagement of various government agencies, non-governmental organizations and industry, Mensah (4). Translating global commitment into national action became an agenda for NCD and risk factor responses across different countries in sub-Saharan Africa (77). Despite these undertakings, by 2015, more than half of the African countries were reported to have failed to achieve the set target [4], further suggesting that the African Union sub-regional bodies, Economic Community of West African States (ECOWAS), East African Community (EAC), Southern African Development Community (SADC), and Community of Sub-

Saharan States (CEN-SAD) could play a stronger role in advocating for more NCD policy efforts in Africa.

Global governance structure

A growing number of studies that explore the adoption of prescribed global recommendations for NCD policy development in sub-Saharan Africa have revealed challenges regarding implementation, indicating a tapered approach (non-adoption of certain recommendations). Thus, Mwagomba et al. (84) report that Nigerian alcohol policy included only three of the twelve national policy documents' ("Best Buys") interventions. In other country studies, an acknowledgement was made of the effect of translating the UN Declaration to national policies, and policy documents aligned strongly with international documents. However, there is limited local evidence to support this finding in practice (6).

Additionally Mocumbi et al. (85), Metta et al. (86), and Borges et al. (87) identified constraints encountered in the political context, in that it is complicated by the global-level challenges and legal boundaries of state sovereignty. Furthermore, Bosu (22) highlighted the challenges causing a lack of specific policies to address NCDs, including lack of information, limited awareness campaigns to sensitize the community to respond, poor coordination, and weak policy and programme management. Essue et al. (70) described weaknesses in priority setting, weak institutions, and insufficient mechanisms to ensure accountability for decision making as a major impediment. Juma et al. (25) reiterated these constraints by signalling weak political will, coordination complexity, and inadequate resources as a major challenge that was common across country studies. Wickramasinghe et al. (71) further describe these challenges and indicate that cultural and bureaucratic barriers to policy development, and the non-functioning multi-sectoral approach as major obstacles in the response to NCDs and risk factors in the study countries.

In conclusion, the literature suggests that although the UNGASS 2011 and WHO Global Action Plans created momentum for the successful adoption and implementation of action plans, they have not been fully implemented as intended. In several African countries, the policy development agenda on NCD and risk factor response is mainly top-down, with the central government playing a central role through the Ministry of Health (74). Lastly, the study countries advocated for the adoption of the Multi-Sectoral Approach model, but there is little evidence from the literature to support that it works in practice

(77) or to demonstrate meaningful engagement by the tobacco and alcohol industry. Only the diabetes interest group in Kenya played a major advocacy role.

4. Issue Characteristics

The fourth domain of Shiffman and Smith's framework (27) looks at three factors: (a) credible indicators, which are clear measures that show the severity of the problem and can be used to monitor progress; (b) severity, where the focus is on the size of the burden of the disease relative to others; and (c) effective interventions, whereby the extent to which the proposed means of addressing the problems are explained in terms of how they are cost effective, backed by scientific evidence, simple to implement, and inexpensive.

Credible indicators

According to Shiffman and Smith (27), credible indicators can be used to assess severity, monitor progress, and the size of the burden. All these factors can determine political priorities in response to NCDs and risk factors. The global burden of disease indicators as well as WHO data provide evidence for these credible indicators and NCD disease burdens globally, in SSA, and in Botswana. The reviews suggest that In SSA and Botswana, significant strides have been made on paper to respond to NCDs and risk factors, but that there are still major gaps in the policy development arena and implementation, despite the availability of credible indicators.

Severity

In terms of the severity of the problem, increasing and undisputed evidence indicates that NCDs are the leading cause of mortality worldwide, with more than 80% of chronic disease deaths occurring in LMICs (29). Annually, NCDs account for 39 million out of 56 million global deaths from all causes (7). More than 15 million NCD deaths are premature, taking the lives of people at their most productive age of between 30 and 70 [2]. The World Health Organization (29)(WHO) forecasts that the African region will experience steep rises in NCD incidence and related mortality over the next decade. For 2015, Tapela et al. estimated that 34% of all deaths (3.1 million) in sub-Saharan Africa were due to NCDs, with 32 million deaths occurring in low-and middle-income countries (10). Given this burden, Collins et al. (8) drew attention to the challenges the region could face, largely due to inaccessibility or a lack of quality of services to the rural poor. WHO Reports (75) and (10) show that the rising burden of NCDs in Botswana is of great concern and a threat to the achievement of the Sustainable Development Goals 2016-2030 and the country's

Vision 2036. According to the WHO (88), an estimated 38% of deaths in the country in 2014 were due to NCDs. However, the literature does not reflect how key decision makers in sub-Saharan Africa, particularly Botswana, view this burden. This is important because these views can affect the actions taken.

Effective interventions?

Nevertheless, there is an increasing body of evidence from sub-Saharan Africa that shows how some countries respond to NCDs and related risk factors, despite the challenges of limited awareness by the communities, scarce human resources, lack of financial commitment, absence of political leadership, and non-stakeholder involvement (75). However, since a half of African countries did not achieve the targets they set in response to NCDs, the AU sub-regional bodies (SADC, ECOWAS, EAC, and CEN-SAD) should play a stronger role in advocating for robust NCD policies in Africa. Borges et al. [3] argue there is reasonable and robust evidence to suggest that countries seem to have done very little to address the increasing use of alcohol, its associated burden, and challenges related to NCDs. In Botswana, the BIDPA (2017) study to evaluate the 2008 national interventions against the harmful use of alcohol, the 2010 National Alcohol Policy, and other subsequent measures indicated that alcohol consumption was on the rise, with people spending more of their household finances on alcohol (28). This means that the alcohol levy policy did not achieve the intended policy objectives to discourage people from buying expensive alcoholic beverages. The BIDPA (2017) report also indicated that the Alcohol and Substance Abuse Division which oversees the implementation of the National Alcohol Policy often cannot cope with the workload. For their part, the alcohol industry in Botswana argued that when the levy and other measures were introduced, they were not consulted and that there was no research to back the intervention or benchmarking (68), (28).

2.4 Opportunities and barriers relating to the WHO Best Buys

The review of literature also included a documentary review. Most of this review and analysis is presented in Chapter 4, but here I focus in on the WHO Global Action Plan "Best Buys" 2013-2020.

NCDs, particularly the four main NCDs of cardiovascular diseases (CVD), chronic respiratory diseases (CRD), cancer and diabetes, are now found to be responsible for almost three quarters of all deaths worldwide (70). The disease burdens of these four diseases could be significantly reduced through public policies focusing on their

common risks factors, especially tobacco use, harmful use of alcohol, unhealthy diet, lack of physical inactivity, and air pollution (70). However, despite being the leading cause of morbidity and mortality globally, WHO has reported that progress in preventing and controlling NCDs and their risk factors has been insufficient and only a few countries are on track to achieve SDG target 3.4, which aims to reduce by one third premature mortality from NCDs by 2030 (19). To address this gap, WHO developed the WHO Global NCD Action Plan (commonly referred to as "Best Buys"), initially for the period 2013-2020, and then extended to 2030 by the World Health Assembly (19). The "Best Buys" were developed to raise the priority accorded to the prevention and control of NCDs in global, regional and national agendas and promote the internalisation of agreed developmental goals through strengthening international cooperation and advocacy (89), as well as facilitating the realisation of sustainable development goal (SDG) 3 on good health and wellbeing (90), (89).

Bhatia et al. argue that although the "Best Buys" have been endorsed by WHO for tackling NCDs, there are arguments that the proposed interventions should not be generalised or necessarily expected to be cost-effective in all settings; there is no one-size-fits-all strategy (91). The authors therefore recommend that NCD decision makers use locally context-specific cost-effectiveness analyses to prioritise interventions in order to undertake effective implementation (79). Despite these concerns, the WHO Global Action Plan 2013-2030 developed six primary objectives, each with a specific area of focus recommended for adoption and implementation by the WHO member states (89).

These objectives are as follows. **First**, to give priority to tackling prevention and control of NCDs at the global, regional and national level. This objective covers raising public and political awareness and understanding and practice about prevention and control of NCDs, as well as to integrate NCDs in the social and development agenda and to engage and mobilise civil society and the private sector. **Second**, to develop and enhance policy and plans at the national level to accelerate country responses for the prevention and control of NCDs. **Third**, to develop interventions for common basic risk factors (tobacco use, unhealthy diet, lack of physical inactivity and harmful use of alcohol). Reduction of tobacco and alcohol use have received particular attention. The overarching actions for reduction in tobacco use include, amongst other things, to strengthen the effective implementation of the WHO Framework on Tobacco Control (FCTC) and its protocols, which have recommended interventions such as increasing excise taxes and prices on tobacco products, and enacting and enforcing comprehensive bans on tobacco

advertising and sponsorship. The reduction of the harmful use of alcohol and its enabling factors entail implementing applicable recommendations in the WHO Global Strategy to reduce the harmful use of alcohol through multisectoral actions, and implementing the WHO Global Action Plan on Alcohol 2022-2030, as well as strengthening leadership and increasing commitment to address the harmful use of alcohol (with the recommended interventions of enabling and enforcing bans or comprehensive restrictions on exposure to alcohol advertising, increasing taxes on alcohol beverages, and reducing hours of sale) (89). Furthermore, in order to achieve objective 3 on health promotion, communication is an essential component in the response to NCDs. Communication capacities are needed to promote health in other sectors. Health professionals need to demonstrate powerful skills in communicating with other ministries, shifting discussion from price to value of interventions (92). There is a need for communication strategies to raise awareness and improve health literacy. In Botswana this is the responsibility of NAHPHA.

The **fourth** objective entails promoting research on the prevention and control of NCDs. This can be achieved through various actions: managing the four main NCDs and ensuring the adoption and implementation of recommended interventions; scaling up early detection and coverage of NCDs; training the health workforce as well as strengthening the capacity of health systems and services delivery at national and primary health care levels; and integrating NCDs into the primary health care package with referral systems to all levels of care to advance universal health coverage. The **fifth** and **sixth** objectives address promotion for the prevention and control of NCDs with the specific aim of developing and implementing a prioritised national research agenda for NCDs as well as budgetary allocation for research on NCDs. The **sixth objective** focuses on monitoring and evaluation at all levels, global, regional and national. The strategy includes developing national targets and indicators based on global monitoring frameworks and linked to a multisectoral policy plan, increased surveillance and monitoring and evaluation (89).

NCDs now account for a large share of premature deaths and poverty, with their burden particularly rising in sub-Saharan Africa (SSA). There is a need, therefore, to increase the priority and allocations for NCD prevention, control and surveillance in national health budgets in these settings (92). There are increasing calls for development partners to consider including NCDs and risk factors in external assistance, with particular focus on effective, appropriate and cost-effective interventions in accordance with national priorities. Studies, including those reviewed above, have shown that as an endeavour to

meet the six “Best Buys” objectives, many countries in SSA including Botswana have shown commitment to respond through the development of national legislative frameworks and policies on harmful use of tobacco and alcohol, following the WHO framework on tobacco and harmful use of alcohol respectively. For instance, in Zambia, Mukanu et al. point out that the government’s response to NCDs was a result of international strategies promoted by WHO (93). The government of Zambia developed the NCD Strategic Plan based on the WHO Global Action Plan for NCDs 2013-2030; this was driven by the government through the Ministry of Health, which set the agenda and adopted the document (93).

Shiroya et al., however, argued that despite the concerted efforts by countries in SSA, the level of policy development in the response to NCDs has been relatively slow and inconsistent (68). Similarly, Tapela et al. stressed that Botswana’s response to NCDs was relatively recent and the development of the national strategic framework to respond to NCDs occurred only in 2016 (10). The authors indicate that prior to 2016, Botswana did not have a national policy or strategy for NCDs despite the fact that the UN General Assembly on NCDs in 2011 as well as the WHO Global Action Plan “Best Buys” 2013-2020 had called member states to develop mechanisms for response. The country level response to NCDs was slow and uneven, as will be shown later in this thesis, in Chapters, 4, 5, 6 and 7. The above statement by Shiroya and colleagues regarding the slow response by SSA resonates with work by Walbeek et al, on the experiences in tobacco control in South Africa (55). Some countries have also started to raise taxes and prices on sugar-sweetened beverages to save lives (94). Similarly taxes have been recommended for salt reduction by the WHO.

Both Thomas and Kickbusch in separate analyses have argued for shifting attention to the commercial determinants of (ill)health (CDoH), that is, tobacco and alcohol as well as sugar, demonstrating that the industry representatives and media can hamper or delay both the adoption and implementation of the “Best Buys” (92) 95). In some settings, state institutions are enmeshed and influenced by corporate actors and the latter influence public health enabled by the state’s failure to protect the health of the population (92). This argument is shared by Shiroya et al. who find that while the policy negotiation process to implement the “Best Buys” has had some success, it is hindered by challenges ranging from antagonism among some commercial actors to factors beyond the health sector (68).

Commercial determinants of health (CDoH) are defined by Kickbusch and colleagues as the strategies and approaches used by the private sector to promote products and choices that are detrimental to health (95). This lens has been applied to a range of industries (e.g., the tobacco, alcohol, food, and pharmaceutical industries) helping health researchers identify approaches that can be applied to improve how corporate practices shape health (96). There are specific pathways through which corporates determine the health and wellbeing of the population. In the case of Botswana, the alcohol industry and medical insurance industry are predominantly focused on the profit motive as opposed to provision of health. The former uses Corporate Social Responsibility (CSR) strategies which are increasingly used to deflect attention and polish corporations' public health reputations (92). As a result, this intersection of power and influence related to CDoH affects public health intervention strategies, where the industry uses legal strategies to oppose public health initiatives, to oppose market restrictions and lobby against health legislation (92). As shown later in the thesis, this has been the case in Botswana where the alcohol, tobacco and medical insurance industries have implemented actions to distort the public health agenda through their efforts to maximise profit via lobbying.

According to Loffreda et al. (2019), the industry involvement and lobbying influence how interventions are framed (97). The WHO former Director General Margaret Chan (cited in Kickbusch et al. 2016) has noted that "efforts to prevent noncommunicable diseases go against the business interests of powerful economic operators" (95). These powerful entities sell alcohol and tobacco which is an important business sector in Botswana as discussed in detail in Chapters 5 and 6. Concomitant with commercially caused or "industrial epidemics" and the country's limited response to NCDs, the utilisation of the "Best Buys" is further hampered by economic and political factors, including changing aid flows and changing actors, as discussed in Chapters 5, 6 and 7 of the thesis.

WHO's "Best Buys" are acknowledged to be inherently complex interventions, that target multiple participants, groups, or organizational levels (98). The strategies recommended for use, as illustrated in the WHO Global Action Plan 2013-2030, require multifaceted adoption, uptake and integration and seek to achieve impacts via multiple components which are subject to diverse mediators and moderators (41). In the case of Botswana, the country's development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs would appear to support the "Best Buys" adoption and integration. However, the study findings in Chapters 5, 6 and 7 indicate that the contextual factors such as economic, political and cultural factors have hampered progress in the successful

implementation of the “Best Buys”. Although NCDs were first included in the National Development Plan 11, there has been limited financial budget as well as lack of sufficient support from developmental partners, exacerbated by donor flight. Essue et al. (70) argue that despite NCDs being a health priority, priority setting was not entirely successful due to insufficient resources and inconsistent involvement of stakeholders, with Wickramasinghe et al. (71) citing cultural and bureaucratic challenges as the major constraints. The sentiments presented by Essue et al. (70) are also supported by the study findings in Chapters 6 and 7 of the PhD thesis.

Despite the development of the WHO “Best Buys”, the UN General Assembly High Level Meeting in 2018 highlighted that most member states were not on track to achieve required progress with NCDs (99). A host of reasons have been advanced for this lack of progress, which include among other things, contextual, historical, economic and cultural factors. Contextual factors according to Allen et al. and Shiell et al. influence the ability to define and pass policies (99(98). Globalisation as well as the double burden of disease have been cited as key contextual factors hampering policy development for NCDs (98). Globalisation impacts through various ways such as bilateralism and multilateralism, and international treaties and protocols, which have to be agreed and signed by multiple stakeholders. Donors also continue to set agendas, sometimes affecting aid and its effectiveness. The global health architecture shapes the global, regional and national level responses to NCDs. With respect to NCDs, as shown in the thesis, the UN Political Declaration on NCDs 2011, the WHO “Best Buys”, as well as the WHO Global Alcohol Action Plan and the WHO Framework Convention on Tobacco Control, serve as the corner stone on how globalisation may act as both a necessary tool of support but also as an impediment. Furthermore, this process may also act as an impediment to policy development in that the recommendations from “Best Buys” for instance may not be appropriate for or appeal to stakeholder in local settings.

Many of the countries in SSA, including Botswana, are also faced with competing emergencies such as the double burden of disease and having to deal with communicable and non-communicable diseases. This creates competing priorities for planning and budget allocations. As a result of this, there is need to prioritise development objectives and ensure proper budget allocations as well as strategic prioritisation and planning.

Global processes leading to the adoption of Western lifestyles have also been cited as a

way in which globalisation may hamper policy development, through corporate food and drink chains such as MacDonalds and Coco-Cola and related shifts in consumption. Furthermore, Jakovljevic et al. stressed that there has been a declining trend in international donor aid intended to cope with NCDs (100). This has been the experience in Botswana where multilateral agencies such as the Bill and Melinda Gates Foundation, Merck and others, as discussed in Chapters 5 and 6, continue to prioritise donor aid for communicable diseases.

Objective 1 of the WHO Global Action Plan 2013-2030 also emphasises the participation of civil society and the private sector in the response to NCDs. Civil society is therefore seen as a crucial resource and partner to the public sector in responding to NCDs. In most countries, the literature shows that while governments and civil society need to work together in NCD responses, challenges persist in ensuring meaningful participation of civil society, as demonstrated in Chapters 5 and 6 of this PhD thesis. Civil society remains relegated to the periphery, without an opportunity for those with experience and advocacy roles to contribute knowledge and perspectives for tackling the NCD epidemic. There has been minimal involvement and participation of civil society in different settings, as pointed by Loffreda et al. (97). Recommendations from the global literature include that policy makers should establish a platform for meaningful engagement with civil society and community members, to ensure multisectoral collaboration.

2.5 Conclusions

The literature review demonstrates that credible indicators of NCDs and risk factors are rising in sub-Saharan Africa. This has created a platform for the issue to become more prominent on national policy agendas, which may lead to policy change, provision of additional resources, political commitment, and greater involvement of the relevant stakeholders. However, the literature indicates that country-level policies have been relatively slow and uneven and differ for particular risk factors. The literature from the study countries clearly shows that there is too much control from the central government through the Ministry of Health, which plays a central coordinating role but which tends to not fully engage stakeholders in sectors such as the alcohol and tobacco industry, civil society and other private sector industry. A fuller application of the Shiffman and Smith (27) framework as a comprehensive logical model that considers all aspects of policy development may help guide key decisions for future NCDs and risk factors.

This chapter also examined the WHO “Best Buys”, in terms of the opportunities it offers and whether countries in sub-Saharan Africa appear to be adopting its key objectives and measures for tackling the NCD epidemic. The WHO recommended “Best Buys” are based on evidence and recommended for adoption by governments, but their implementation is not on track. Governments face challenges in adopting and implementing many of these interventions due to historical, cultural, political and economic conditions. The critique of the “Best Buys” suggests that they are not necessarily quick fixes and given that the benefits of NCD prevention policies and interventions may not be felt during contemporary political horizons, they are difficult to justify for many political actors. It might be a more productive approach to recognise “Best Buys” as a political process, which requires a thorough analysis of the actors, contexts and power dynamics that enable these processes, to inform their successful implementation. Furthermore, a significant number of the “Best Buys” policies need to be implemented by other sectors or with other sectors, requiring coordinated cross-sectoral action and commitment. Even where political will exists, the implementation of the “Best Buys” is often constrained by lack of adequate local capacity for implementation, limited awareness by the general public, communities and policy makers about NCD prevention, as well as the general absence of guidance as to how to adapt the recommended interventions in any given context. Ignoring the policy process leads to policy failures in implementing effective NCD responses at country level.

Chapter 3: Methods

This chapter presents the study design and methodology used to answer the research questions. I describe the data collection methods used and why they were chosen, and describe the data collection processes, data storage and analysis, and the ethical clearance obtained for the study. This thesis uses policy analysis to provide an analysis of NCD policy in Botswana which, where relevant, draws parallels and lessons from the HIV response.

The study used qualitative data collection methods as discussed below. Semi-structured interviews and document analysis were selected as the most suitable combination of data collection methods. Interviews were semi-structured, and 28 participants were interviewed, as discussed below. Furthermore, policy documents, reports, and newspapers were selected based on an extensive review and assessment of available national documents. Thematic analysis and coding schemes were used to analyse qualitative data and NVIVO 11 data management software was used to organize the data for analysis. The findings from the document review are presented in Chapter 4.

Safety measures were employed to ensure data security. Approvals to carry out the research and data collection were received from LSHTM (reference number 22620), University of Botswana Ethical Review Board (reference number UBR/RES/IRB/SOC/105) and the Ministry of Health Ethical Review Board (reference number HPDBME:13/18/1).

The research carried minimal direct risk to the participants, and no financial incentives were offered. The data collection methods for each objective are summarized in Table 1 and each is now discussed in turn.

Table 1 Summary of methods and research questions by objective and conceptual framework domain

Objectives	**Domains: Actors, Context, Issue Characteristics, Process**	**Methods**	**Question**
1: To analyse the policy framework that underpins the development and implementation of the NCD policy response in Botswana. The above based on the conduct an exploratory literature review on the evidence in relation to policy development for NCDs in sub-Saharan Africa	Actors, political context and Issue characteristics Overview of evidence in each domain through an exploratory review	In-depth interviews; review of policy documents and reports Literature search using PubMed, Google Scholar and grey literature (see Chapter 2)	• How have actors taken advantage of the policy window created by UNGASS, WHO "Best Buys". • To what extent has policy development been aligned with political forces? • How were different and development of the Botswana National Strategic Framework on the Prevention and Control of NCDs and policies contributed in the response or not. • NCD policy development.
2: To undertake an analysis of actors – Guiding Institutional actors active in the NCD response and involved in NCD policy development in Botswana (relating to service delivery and risk factors).	Actors – Policy development & design and policy formulation,	Key informant interviews with policy makers; review of policy documents and reports	• What are the guiding institutions and process through what they shape policy. • What are their formal roles and responsibilities according to both their described official mandates and their actual incentives and actions? • What different actors are involved in developing NCD policy (both for service delivery and prevention of risk factors). What are their commonalities and differences? What are the guiding institutions and processes through which they shape policy? What are their sources of power? What are the actors' roles and responsibilities on policy development in response to NCDs and how do they coordinate?
3: To analyse the wider group of actors involved in the NCD response in Botswana.	Progress & policy reports.	In-depth interviews with the stakeholders,	• How are they involved in policy making or policy (un) making. • What are their commonalities and differences.

		community leaders and civil society and development partners	• What is their source of power.
4: To consider the difference in actors' perceptions of the HIV/AIDS policy response in their context.	Policy reports, progress reports, website portals. Outcomes. Credible indicators which can trace the severity and progress.	Key informant interviews; the review of documents	• What are the perceptions for treatment of NCDs? • What are the underpinning values? • What lessons can be drawn from HIV? How does HIV differ from NCDs? What are the similarities?

3.1 Exploratory Review of Literature and Document Review

Two reviews of literature were carried out for this PhD study. First, *a scoping or exploratory review of academic literature* was performed to examine the existing literature on NCDs and policy analysis in sub-Saharan Africa and Botswana. This literature review has already been presented in Chapter 2, including its methods and the inclusion or exclusion criteria for the selection of the 44 papers or documents reviewed.

Second, the PhD study also used a *structured policy document review* to analyse policies and documents relevant to understanding NCD responses in Botswana. These findings for the thesis are presented in Chapter 4. These policy documents were identified using the search method described in Chapter 2, and policy documents were also identified by key informants before or at the end of each interview.

The subject matter of this study is government-led policy, which can also be called 'public policy' (18) for NCDs. A classic definition of public policy is anything a government chooses to do or not to do (101). This definition draws attention to the fact that policy is much more than what is contained in policy documents or legislation, (102). The pragmatic definition of NCD public policies for the work reported in this PhD study is broad and has been adapted from Buse et al. (21). "NCD public policies are broad statements made by government of goals, objectives and means in order to create a framework for activity directed at the prevention and control of NCDs." The study design aimed to compare stated policies, agenda setting, and planning in key documents with informants' narratives from semi-structured interviews (discussed in section 3.2). The interviews were designed to elicit narratives on the processes of formulating government-led NCD policies and participants' knowledge, insights, and experiences regarding the current state of policy development.

A total of 15 documents were identified and analysed. Five of these were global policy guidance documents, frameworks or tools relating to NCDs (which are relevant to Botswana). These were the UNGASS 2011 Political Declaration, the WHO Global Action Plan "Best Buys" 2013-2020, WHO NCD Program Monitor 2022, WHO Global Alcohol Action Plan, and the WHO Framework Convention on Tobacco Control (FCTC) . Ten were national policy or related documents (e.g., donor reports)

specific to Botswana. These documents were, the Botswana Health Policy, Botswana National Development Plan Eleven (11). Botswana Vision 2036, Botswana Multisectoral Strategy on the Prevention and Control of NCDs, Botswana Alcohol Policy and the Controversial Alcohol Levy, Botswana National Strategic Framework for HIV/AIDS 2019-2023, State of the National Address (SONA) formal report 2019, Essential Service Package (ESHP), National Policy on Mental Health, Control of Smoking Act, BIDPA report. Newspapers were also searched (using the internet) for relevant articles on the NCD response. Each document was examined for policy statements (stated goals, objectives, or means of achieving goals). In addition, documents were examined for statements on establishing overarching structures, processes, and funding arrangements relevant to NCD prevention and control, such as a multi-sectoral approach in response to NCDs and risk factors in the country. Table 2 in Chapter 4 describes all the documents selected and summarises the reasons for selection of each of the documents, and for which themes they were relevant for understanding.

3.1.1 Inclusion and exclusion criteria for the document review

Table 2 in Chapter 4 shows the 15 documents that were selected for this PhD research, their relevance to the topic, and summarises the inclusion criteria used to justify their use in the study.

Documents were included if they addressed at least one of the common NCD conditions and their major risk factors, such as smoking and alcohol consumption, as defined by WHO, and if they contained material on strategies or policies in relation to NCDs. Documents were excluded if they did not address the research questions for the study and did not address the country's response to NCDs and risk factors. Documents were also excluded if they did not explicitly report on policy development response to NCDs and risk factors. Furthermore, documents were excluded if they were biased and not founded on empirical evidence or theoretical accounts of NCDs and risk factors. Documents were also excluded if they were too narrow to address the research questions. Data extraction of the documents included, author year, policy target and policy content.

I reviewed the documents, firstly, to describe the content and to categorise the approaches to the NCD response in the country, and secondly, to enrich analysis

and understanding of in-depth interviews and other non-policy documents such as newspaper articles relating to the policy response to NCDs.

Newspaper articles were searched using the internet. They were included if they addressed at least one of the common NCD conditions and their major risk factors, such as smoking and alcohol consumption, as defined by WHO, and if they contained material on strategies or policies in relation to NCDs. Newspaper articles were excluded if they did not address the research questions for the study and did not address the country's response to NCDs and risk factors. Newspaper articles were also excluded if they did not explicitly report on the policy development response to NCDs and the harmful use of alcohol and tobacco use as well as on the role and the response of the industry to the introduction of the alcohol levy, policy and tobacco bill. The newspaper articles were excluded if they were not founded on any empirical evidence and were biased.

A total of 5 newspapers were selected for this study. All these newspaper articles were local and focused on government and industry's reaction to the introduction of the alcohol levy in 2008 and the alcohol policy in 2010 respectively. Two newspaper articles focussed their discussion on tobacco use and the tobacco bill and Tobacco Control Act 21.

I reviewed the newspapers to describe the content and to categorise the approaches to the NCD response in the country, and to enrich in-depth interviews and the document review.

3.2 Semi-structured Interviews

3.2.1 Identifying actors for interviews and analysis

The data collection approach began by identifying the key actors, who are the driving forces in policy development and implementation according to Shiffman and Smith's analytical framework, with all other domains linked to actors' actions and interests. Each actor type was selected to provide specific perspectives on the research questions. Data for each actor were obtained from the in-depth, semi-structured interviews, but other relevant data pertaining to actors were gathered using a mix of other sources (documents, and routine and public information including social media). This process (**presented in Annex E in its starting form**) was iterative as new actors and data sources emerged during the study.

The actors were identified using the following steps:

A) Examining the types of actors found in the literature review to be influential in the development of NCD policies in sub-Saharan Africa, and identifying these in relation to Botswana's policy development.

B) Mapping the actors (institutions or individuals) specific to the Botswana context using the main components of Shiffman and Smith's actor domain components: cohesive leadership, a guiding institution and the mobilization of civil society. Snowball sampling was used, which was also informed by an initial analysis of the interviews.

C) Identifying broader governance structures within which key institutions (actors) are located.

All data collection for the semi-structured interviews was undertaken by the principal researcher, with the assistance of two research assistants based in Botswana. Due to the COVID-19 outbreak, it was not possible to conduct face-to-face interviews, and as a result, the interviews were conducted using the Zoom and Teams Apps, in accordance with LSHTM and the Ministry of Health and Wellness and University of Botswana ethical practice guidelines. The bulk of the data collection took place in Botswana.

Annex E provides a summary of the key institutional actors identified through literature and document review and key informant interviews according to their relevance for the research.

3.2.2 Semi-structured key informant interviews

The second data collection step involved conducting semi-structured interviews with key informants from the government, civil society, industry (private sector), and UN agencies. The key informants targeted in this study were those who had been involved with or participated in the government's NCD policy development process, and related risk factors, within and outside the health sector [43]. Snowball sampling was then utilized, asking each informant after the interview if they knew anyone else who would have information for the study.

An invitation was sent by email to explain the purpose of the interviews and the research conducted, explaining that it was part of a thesis to obtain a PhD in

LSHTM. If there was no response to the email, a week after the email was sent the interviewees were contacted by phone at least four more times. If they agreed to be interviewed, an appointment was set and the respondent was asked to sign and return an informed consent form (See **Annex F** for the information sheet and consent form). A total of 28 key informants participated in the study.

Between April and September 2021, a total of 50 individuals were invited to participate in this study. Of these, 28 of them were interviewed while five informants declined, and others did not respond or wish to participate, without giving any reasons.

Semi-structured interviews were conducted with four senior informants from the Ministry of Health and Wellness (MoHW) to provide a narrative on the policy development process of NCD policies, and insights and experiences on the current state of NCD and risk factor responses in the country. Further interviews with 24 key informants outside the MoHW were used to provide an outsider perspective, as these informants were identified as relevant stakeholders.

Semi-structured interviews were guided by a predefined list of questions or topics related to aims and objectives, (103). Shiffman and Smith's framework was used to guide the design to keep the topics focused on those relevant for the study during interviews. See **Annex D**, and **Annex G** for the topic guide.

The interviews were conducted in English (interview guides were translated into Setswana where necessary) and lasted for approximately 45 minutes to an hour. Written or verbal consent was obtained, with verbal consent obtained if the interviewees wanted to participate but did not wish to sign. To conduct the interviews, the researcher designed a topic guide for the semi-structured interviews, which was piloted in advance of the study with three interviews and revised before it was used with other participants and respondents. The topic guide (**see Annex G**) included questions about actors and stakeholders, knowledge of the policy development process in response to NCDs, and risk factors in the country.

As noted above, due to the COVID-19 outbreak, it was not possible to conduct face-to-face interviews, and instead interviews were conducted using the Zoom and Teams Apps. Notes were written up in full immediately after the interview. All recorded interviews were transcribed by the researcher (or research assistants)

shortly after the interviews to allow for concurrent analysis. Interviews were digitally recorded and downloaded to a personal computer. All data collection was undertaken by the Principal Researcher with the assistance of the two research assistants., one male and one female; both were Master's degree holders from the University of Botswana. The research assistants recruited were already trained and had participated in other research projects, and had also assisted in research surveys, but for the purpose of this study I had to train them on the topic guide, qualitative interview techniques and ensure the quality of their work. Transcription was done using Otter and I went through their transcripts to cross-check them.

Participants were purposively selected based on their roles and experiences. For example, civil society' actors were selected to inquire about their role in advocacy, technical support, partnering implementation, and also their role in monitoring the commitment of the national government. Industry stakeholders were interviewed to examine the extent to which they exert influence, for instance by promoting commodities detrimental to health. Based on the literature review, all selected actors play a critical role in their specific areas of jurisdiction. For example, UN agencies were interviewed to assess the extent and magnitude of their involvement and influence in the response to NCDs in Botswana. Interviews explored whether their roles are confined specifically to offering technical assistance, or whether they also exercise authority and dictate terms in relation to conformity and compliance with the UNGASS declarations and WHO "Best Buys" interventions, the WHO Framework Convention for Tobacco Control (FCTC) and the WHO Global Strategy to reduce the harmful use of alcohol. These interviews also explored to what extent these actors influence the prioritization of activities and funding for the NCD response, if at all, and finally, whether these agencies allow room for flexibility for national governments to play a dominant role in policy development without interference from global health actors.

3.2.3 Data storage and analysis

All data, including interview transcripts and field notes, were translated where necessary and all recorded interviews were transcribed. NVivo 11 software was used to collate the data for analysis, (104). A qualitative thematic analysis was conducted. Data analysis was guided by the main conceptual framework, and the analysis, in turn, contributed to the further refinement of the conceptual

framework. The framework was used as a structure for the analysis, was used to identify sub-themes, and was also open to other emerging sub-themes. Analysis began with familiarization with the data by reading through all the transcripts, listening to selected audio recordings, and developing a summary of the raw data, to provide an overview of each case. A timeline of key events was developed. Thematic content analysis was undertaken to develop a coding scheme and a framework table to index all interview contents. If any new topics that were not part of the code book emerged, inductive codes were assigned and added. Following the completion of the coding, I distilled, connected the codes, and identified the themes. They were presented in a coherent narrative, drawing on memos during the analytical process. This method was chosen for this study because it allows for a mixed approach using both deductive and inductive analyses. The initial coding was reviewed by the two PhD supervisors. This methodology helped to identify the main aspects of the NCD and risk factor policy development process in the country, to understand the role of the guiding institutions, and to identify the framing of the issues.

3.3 Data protection and security

The interview transcripts were stored in a password-secured folder. All interview files were anonymized using an alpha-numeric code. The audio recordings were only accessible to the PhD candidate and a research assistant, based in Botswana, who helped with transcribing using the Otter app. The transcripts were stored securely in the candidate's home in London. Information storage satisfied the security and ethics requirements of the study and followed standard LSHTM ethics and good data management practices.

3.4 Ethics

Ethical approval was obtained from the ethics review boards of LSHTM, the University of Botswana, and the Botswana Ministry of Health and Wellness.

3.4.1 Consent

Written informed consent was obtained from all the participants who were requested to participate in the interviews. Consent forms were made available in English and Setswana (**see Information and Consent Forms, Annex F**). The research consent process followed the guidelines of the LSHTM ethics review

board, the University of Botswana ethics review board, and the Botswana's MoHW ethics review board.

3.4.2 Risks to participant and participant confidentiality

The research carried minimal direct risk for the participants, no financial incentives were offered, and no personal or private questions were asked. All data is protected, but additional care has been taken with data that may be politically sensitive (e.g., critical opinions of policies supported by powerful actors).

3.5 Delays to the Research Process

Due to the unprecedented outbreak of COVID-19 the principal researcher could not travel to Botswana to conduct face-to-face interviews and had to carry out interviews from London, UK, which caused many delays and costly telephone expenses as follow ups to the invitation emails had to be made. Research assistants were employed to support the principal researcher in conducting the primary research in Botswana, and to enable the collection of more diverse data. Terms of Reference for the role of the research assistant were developed. It was anticipated that the interviews and document collection would take a period of 6–7 months to complete; however, approval from the three ethical review boards was delayed by about seven months and interviews started very late. Coupled with this, the researcher fell ill and had surgery that delayed the entire study process.

The next three chapters will present the study findings, starting with the policy review (Chapter 4).

Chapter 4: Policy documents supporting NCD response: analysis of scope and limitations

4.1 Introduction

Non-communicable diseases (NCDs) are now a global health concern, and in Botswana, evidence shows that NCDs increasingly pose a burden on the population and the health system of Botswana, compelling the government to respond in some way. The development of the flagship Botswana Multi-sectoral Strategy for the Prevention and Control of Non-Communicable Diseases (NCDs) was led by the government through the Ministry of Health, in response to international strategies from the UN Political Declaration on NCDs in 2011 and the WHO "Best Buys" 2013-2020. A range of policy and strategy responses to NCDs have been developed over the years and this chapter critically examines these to gain a greater understanding of the response to NCDs and their risk factors in Botswana, and to consider actor mobilisation, inertia and the extent to which they enable or impede NCD response action or inaction in the country. This structured review of documents seeks to undertake an in-depth analysis of how these policies and strategies enable action on NCDs presented in the subsequent chapters.

4.2 Methods

4.2.1 Document analysis

Bowen defined document analysis as a systematic procedure for reviewing or evaluating documents, which can be used to provide context, generate questions, and corroborate other studies (105). Such document can be regulations, policies, guidelines, media accounts and others). Document analysis can describe document goals, specific objectives, and the strategic priorities of the policy these documents relate to. It can provide valuable insights into how policies were developed, and it can contextualize present actions to implement or not implement them. For this study, documents were examined for any statements on establishing overarching structures, processes, and funding arrangements relevant to NCD responses. Furthermore, each document was examined for specific or general policy statements (stated goals and objectives). For this study

various types of documents were included and reviewed: regulations, policies, strategies, research reports and newspaper articles.

4.2.2 Identification of documents

Documents pertaining to NCDs and risk factors, from global health initiatives to national and sub-national levels, were reviewed. With respect to global documents, I examined their relevance to the context of Botswana, tracing how these shaped the policy development response to NCDs and risk factors, and the extent to which the policies were effective. These documents were identified through advice from key informants, prior to or at the end of each interview, as well as from the Ministry of Health of Botswana and other relevant stakeholders from civil society, industry, the WHO, and other UN agencies.

The national documents reviewed were identified through exploring the websites of the Government of Botswana, the Ministry of Health and Wellness (MoHW), research institutes, UN agencies and non-governmental organizations, and following that, confirming these with the MoHW Director (see Table 2 below).

General web searches were also conducted using the Google Scholar search engine to assist in identifying relevant Botswana government policies and reports. Information on national programmes and strategies was also obtained through individual approaches to senior public health professionals in the country. Some of the documents identified were unavailable electronically and were obtained in hard copy. The documents reviewed included several types of global policy guidelines and tools, national policies and strategic plans, national and donor reports, and published articles on NCDs in Botswana, as shown in Table 2 below. Following the description of the policies in Table 2 in Chapter 4, subsequent sections then consider each policy in detail, describing how they have contributed to shaping Botswana's NCD response.

Table 2: Global and national documents selected for the policy review

Name of document	Description / at what level enacted, key points and implications	Reason for selection: Inclusion criteria	Relevance to themes pertinent to the study questions
GLOBAL POLICY DOCUMENTS RELEVANT TO NCDS AND USED OR REFERENCED IN BOTSWANA			
WHO "Best Buys" 2013-2020 (and WHO Global Action Plan for the Prevention and Control of NCDs (2013–2020))	The "best buys" (May 2013) comprise health interventions that are globally recommended as best practice for NCD control. The "best buys" (global action plan) has six objectives. Part of this plan comprises a menu of policy options and cost-effective and recommended interventions. Progress in implementing the 2011 Political Declaration was insufficient and highly uneven. The outcome document of the July 2014 UN review included the setting of national NCD targets consistent with global targets, developing national NCD multi-sector plans by 2015, and starting implementation of those plans by 2016 to achieve the national targets.	The WHO "best buys" were selected to examine the extent to which Botswana adopted and adapted the recommendations set.	To assess the NCD recommendations for adoption and adaptation as prescribed in the WHO Framework.
UNGASS 2011	The UN High-Level Meeting on Non-Communicable Diseases (NCDs) in September 2011 provided an unprecedented opportunity to create a sustained global movement against premature death and preventable morbidity and disability from NCDs. The Political Declaration provided a set of recommendations for countries to adopt or adapt in their response to NCDs and risk factors. A phased, national response to the political declaration was suggested, with three key steps: planning, implementation, and accountability. Planning entails mobilisation of a multisectoral response to develop and support the national action plan, and to build human, financial, and regulatory capacity for change.	Whether the Political Declaration on developing a multi-sectoral approach and inclusion in the National Development Plan have been carried out or not, and why?	UNGASS Political Declarations and the prescribed recommendations offer a policy window for governments. To assess the extent to which the policy window has been utilized.

	Implementation involves a few priority and feasible cost-effective interventions for the prevention and treatment of NCDs. Accountability incorporates three dimensions: monitoring of progress, reviewing of progress, and appropriate responses to accelerate progress.		
WHO NCD Progress Monitor 2022	This Progress Monitor tracks the performance of countries against an agreed set of markers. Indicators, include detailed definitions, specifications, data sources and assessment.	To assess country progress on the NCD response. Which boxes have been ticked, which have not been ticked, and assess why. Are there guidelines for management of cancer, CVD, diabetes and CRD (chronic respiratory diseases)?	Indicators of countries' progress made in the response to cancer, CVD, and CRD.
WHO Global Alcohol Action on NCDs Plan (2013-2020)	The WHO Global Alcohol Action Plan (GAAP) is a document that aims to prevent and reduce the harmful use of alcohol. It provides a global strategy and a set of policy options and measures that can be adapted.	To what extent are the guidelines on policy options adopted or adapted as per the recommendations.	NCDs and alcohol global regulations and recommendations. To what extent have countries developed policies and guidelines to adhere to the set global guidelines.
WHO Framework Convention on Tobacco Control (FCTC)	WHO FCTC seeks to ensure a ban on advertising and ensure tobacco free public spaces.	Examine the Global Framework on Tobacco Control and the regulations recommended for adoption and adaptation. Has the country achieved and used the recommendations in line with the FCTC? If not, what are the gaps and how can these be addressed?	WHO Framework on Tobacco Control Global Action Plan. What does it prescribe? Is it adopted by the government to follow the international set guidelines? Is there a backlash from the industry?
NATIONAL POLICY DOCUMENTS RELEVANT TO NCDS			
Botswana Health Policy.	This document sets out policy measures and clear directions for the development of the health sector in Botswana. It provides policy measures that are	Examine the progress on the implementation process as stated in the strategy, guidelines and	Botswana Health Policy. What does it cover? Is it meeting the stated policy

	supposed to guide strategies and programmes in the health sector.	programmes for health services delivery in the country. PHC and the role of DHMTs. Are they meeting their desired goals or not?	intent or is there a mismatch? What mitigating factors are in place to meet the gaps?
National Development Plan 11 (2017-2023)	Botswana National Development Plan 11 Volume 1 (April 2017- March 2023) is a national strategy developed to guide the medium-term economic development path for the country under the theme Inclusive Growth for the Realization of Sustainable Employment Creation and Poverty Eradication.	The National Development Plan (NDP) defines a desired destination and identifies the role different sectors of society need to play in reaching that goal. It serves as a blueprint for the work that needs to be done to achieve a prosperous society for the country. Has it been able to achieve its intended purpose by including NCDs in the NDP 11? Is it enough just to include them in NDPs without the necessary resources for implementation?	Botswana National Development Plan 11. What does it cover on the response to NCDs? Is it in line with the UNGASS and WHO action plans. Is it supported by the required budget both at national level and sub-national level.
Botswana Vision 2036	This document provides the target sets in the vision and serves as a guide for all the development efforts of the country. It provides set goals and the strategic focus in all economic sectors including health.	It is anchored on four pillars. The pillars are sustainable economic development, human and social development, sustainable development and governance, peace and security. Botswana's Vision 2036 aligns with the global agenda for sustainable development and the principals of Africa Agenda 2063, to ensure that the country pursues the national aspirations in a way that enables Botswana to meet the global and regional goals. Are NCDs and risk factors covered in the Vision 2036	Botswana Vision 2036. Are NCDs covered in Vision 2036? Is it in line with the SDG 2030, 3.4.

		and if so what progress has been made to achieve its desired goals.	
Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs, 2018.	The Botswana NCD Strategy gives the strategic direction for integration of NCD response into the broader health sector plans. It also provides a multi-sectoral approach.	The Botswana NCD Strategy is a key document about the response to NCDs in Botswana. Assess the extent of the implementation of the NCD Strategy. Is the implementation of NCDs multi-sectoral, is it backed by resources and incentives for implementation and is there the political leadership and support?	The Botswana NCD Strategy places emphasis on a multi-sectoral approach both at the national and sub-national levels. Is it supported by budgeting? Does it support integrated health services delivery and does it emphasize adoption of the same structures that were used in the response to HIV?
Botswana Alcohol Policy 2010 & The Presidential Alcohol Levy 2008.	The Alcohol Policy's main objectives are to reduce alcohol consumption, establishment of rehabilitation centres and adhering to set liquor regulations and trading hours. The intended objectives of the levy were also geared towards reducing trading hours and other restrictions.	These are key policies related to NCD risk factors. Restrictions and regulations on operating hours. Examine the extent to which the country has adopted and or adapted the global action plan on the harmful use of alcohol. What is the relationship of the industry with the government? Is there pushback by the industry and what are the mitigating factors put in place to respond to such pushbacks?	Alcohol Levy. Botswana Alcohol Policy. What do they cover? Does the policy cover what is prescribed in the WHO Global Alcohol policy?
Botswana National Strategic Framework for HIV/AIDS 2019-2023.	The purpose of this document is to outline the national priorities for the national response to HIV and AIDS for the period 2019 to 2023. These priorities are based on the evidence accumulated locally and are augmented by international best practices. The overall philosophy behind the framework is that	HIV/AIDS response and priority setting on curative and preventive care. Assess the extent to which the integration of NCDs into health services including HIV/AIDS has been carried out. Are the	Botswana National Strategic Framework for HIV/AIDS. What lessons can be learnt in order to respond to NCDs?

	through collective and concentrated efforts around these priorities we will be able to maximize the impact of the national response.	structures that were successfully used in the response to HIV/AIDS used in the NCD response? If not, why is that the case?	
Formal Reports: SONA 2019.	SONA report and its coverage on health including NCDs. SONA report provides updates on the country's response to health services delivery.	What is the country's progress in responding to NCDs according to SONA?	Does the SONA report cover anything on NCDs, harmful use of alcohol and tobacco?
Essential Service Package (EHSP).	The concept of the EHSP is that all the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programmes. It also entails that all key stakeholders will have an opportunity to contribute their ideas and experience. ESHP consists of four different components: (a) Sexual and reproductive health (SRH), (b) Child health, (c) communicable diseases, (d) non-communicable diseases. In addition, provision of PHC delivery of NCD services was included in the country's 11th National Development Plan (2017–2023).	Is EHSP carried out in the country and to what extent? Is it a piecemeal approach or not? Are all the stakeholders involved or not?	EHSP document review. Primary focus on policy response to NCDs at the sub-national level. Are there gaps and what mitigating factors are put in place to address the gaps?
National Policy on Mental Health.	The National Policy on Mental Health provides a framework for the incorporation of the objectives of the mental health programme into existing general health care services and it is to be implemented through the primary health care strategy.	Examine the extent to which mental health is made an integral part of NCD response. How are mental issues addressed in the country?	Mental Health Policy and reports. Assess the extent to which the country is committed to responding to mental health issues.
Control of Smoking Act 1992 and Tobacco Control Act 2021.	The Tobacco Control Act 2021 was passed by the National Assembly on 16 August 2021. This new Act repeals the Control of Smoking Act 1992. The new law establishes the multi-sectoral Tobacco Control Committee. Those who are engaged directly or indirectly with the tobacco industry cannot be appointed as members of the Committee.	How is the country responding to tobacco use? To what extent is the country using the recommendations from WHO FCTC? The development of the Tobacco Control Act 2021. Was it smooth sailing or was there pushback from the industry?	Is the prescribed Act being utilized or not?

4.3 The Global Policy Landscape: How UNGASS 2011 and the WHO "Best Buys" 2013-2020 (2023-2030) Shaped Botswana's Key NCD policies

Two key events and resulting documents dominate the global policy landscape related to NCD control. The UN General Assembly Special Session (UNGASS) on Non-Communicable Diseases Prevention and Control in 2011 brought together the international community and national stakeholders to raise awareness of, and launch an effective response to, NCDs. This Political Declaration on NCDs, which depicted NCDs as silent killers, was a turning point in the response to the global response to NCDs, setting up a policy window for member states through this declaration to start taking action. The Political Declaration led to the development of a cluster of cost-effective intervention measures dubbed by WHO as "best buys". These WHO "Best Buys" 2013-2020 (now 2023-2030) are a set of menu options comprised of six objectives for the prevention and control of NCDs and risk factors which member states are expected to promote. The "best buys" also provided mechanisms for the countries to develop policies and strategies designed to assist them in reducing harmful use of alcohol and tobacco, salt reduction, tobacco taxation, diet, promoting physical activity and cervical cancer screening.

Botswana's response to NCDs was informed by these international strategies from the UN Political Declaration on NCDs in 2011 and the WHO's 2013 "best buys". The cornerstone of the national policy response for the prevention and control of NCDs has been these two documents, which highlight the priority areas for action and accountability in the health sector, adding to the evidence that NCDs are the leading cause of morbidity and mortality globally and nationally.

The UNGASS statement on Non-Communicable Diseases Prevention and Control in 2011 called for its members, the international community and national stakeholders to take action to respond to NCDs, to raise awareness, and launch effective national responses. Botswana, like most members of the UN, was a signatory to this Political Declaration, and hence, as a result of its recommendations and the set of menus provided by the WHO "Best Buys", the country for the first time took decisive action by including NCDs in the 11th National Development Plan. Furthermore, although late, the country developed the Botswana Multisectoral Strategy for the Prevention and Control of NCDs in 2018. The strategy covered in detail how the response was to be carried out, including

the participation of a range of actors. The strategy notes that its development was multi-sectoral and that it was based on the guidelines from the WHO Global Action Plan for NCDs 2013–2030. The WHO assisted the consultants on the design by providing technical expertise.

The third UN High-Level Meeting on Non-Communicable Diseases (NCDs) on September 27, 2018, took stock of national and global progress towards the prevention and control of NCDs. This process indicated that many countries, including Botswana, had not made significant progress in developing NCD national policies and strategies. Botswana only started to develop its NCD strategy in 2018. Similarly, the WHO Progress Report 2022 indicated that the country was still lacking in its response to NCDs and the building of intersectoral collaborations.

Overall, the document analysis shows that in Botswana, the only national policy instruments related to NCDs that were in place before 2016 were the Alcohol Policy, Tobacco Policy, Nutrition Strategy, Essential Health Services Package, and Botswana Public Health Act. None of these sought to comprehensively address NCDs and a national policy or strategy for NCDs was lacking. It was only after 2016 that the first national primary health care (PHC) guidelines were developed using the WHO Package and its phased three-year implementation started in 2017.

Furthermore, this review indicates that studies on NCDs and PHC in the country are few and the ones that exist report gaps in health services delivery at the sub-national level including provision of poor health care, inadequate diagnostics and access to medicines. The review also indicates that while there is the political commitment to raise public awareness at national and sub-national level, there are challenges due to bureaucratic procedures involved with budget allocation – hampering improved provision and access to quality NCD care.

Compounding a lack of budget allocation, mostly at sub-national level, the document review also shows that there are a lack of other inputs and incentives to effectively deliver NCD care, such as the necessary trained human resources to respond effectively to NCDs. With respect to the total health expenditure on health and NCDs, document analysis indicates that unlike in the response to HIV/AIDS where countries received enormous amounts of funding from donors and local budgets, this is not the case in the response to NCDs; countries are expected to develop innovative ways of initiating and funding NCD responses at country level.

For instance, the global 2005 Paris Declaration on aid effectiveness, Target 8.E, emphasised that in cooperation with pharmaceutical companies, agencies and governments must provide access to affordable essential medicines in developing countries, including for NCDs. These essential medicines are greatly needed in Botswana, for example for patients with diabetes or high blood pressure amongst other conditions. As discussed in Chapter 6, the study found that there are medicine shortages and frequent stockouts. The Paris Declaration was reaffirmed by the 2008 Accra Agenda for Action, with the latter presenting redefining moments in which countries had to take responsibility for developing nationally based funding mechanisms without overreliance on donor aid. This is a very important shift, as the document review indicates that national health systems receive resources and technical assistance from many different donors, international agencies and donors with varied priorities as discussed in detail in Chapter 5 and 6.

The document review also indicates that international NGOs set the agenda and can also exacerbate the weakening of national health systems by providing lucrative packages through their project activities, thus attracting and diverting health workers, managers, and leaders away from the public sector and creating parallel structures to government services that tend to worsen the isolation of communities from formal health systems.

4.4 The Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs (2018-2023): The Nuances of a Multi-sector Approach

This section focuses on the development of the Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs, 2018-2023, which I also refer to as the Botswana NCD Strategy. It is the key document in Botswana responsible for the NCD and risk factor response. This section examines the content of the strategy and its limitations.

According to the document review, multi-sectoral action is widely acknowledged as an essential element for addressing NCDs and is duly recognized by the Political Declaration on NCDs 2011 and the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020. The 2011 UNGASS and the WHO “Best Buys” on NCDs 2013-2020, provided recommendations which member states can undertake. As a

result, this culminated in the development of the Botswana NCD Strategy in 2018 with the following aims:

(a) to identify national priorities for addressing NCDs, with emphasis on prevention, PHC, holistic treatment approaches, and multi-sectoral participation;

(b) to outline a roadmap of efforts and critical activities that will be integrated by various stakeholders in addressing NCDs, and;

(c) to identify primary indicators and targets in order to assess the impact of efforts.

These are assessed below against the six pillars set by the WHO "best buys", to assess progress in the response to NCDs and risk factors in the country.

The Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs (2018-2023) was developed by the MoHW in partnership with the World Health Organization. The document review demonstrated that this strategy has served as a roadmap to energize and guide the country's national response to NCDs. Its purpose is also to put Botswana on track to meet national and global targets, including working towards the Sustainable Development Goals (2016-2030). The country's inclusion of NCDs in the 11th National Development Plan (2017-2022) (NDP11) represented a milestone achievement and was demonstrated in the prioritization of NCDs by the government.

The Botswana NCD Strategy embodies a government commitment to continue to meet the needs of Botswana's population in the prevention and control of NCDs and emphasizes the core role of multi-sectoral engagement and action. Its development was thus multi-sectoral and aligned with NDP11, reflecting its key performance indicators. The Strategy development process included various participating stakeholders, comprising multi-sectoral technical working groups (TWG) including representatives from various ministries and partners. The draft was then presented to the MoHW management, and subsequently to a high-level inter-ministerial forum for vetting and high-level commitment across sectors, as the final step in development and endorsement.

The discussion below focuses on the content of the Botswana NCD Strategy. These include the tenets of Alma Ata PHC and the Botswana National Health Policy's anchoring principles, which are intended to guide the implementation of the NCD Strategy. According to the Strategy, there are four key priority areas identified as

anchors for the strategic objectives and activities for addressing NCDs in Botswana. The analysis indicates that these priority areas and their related strategic objectives are aligned with the WHO Global Action Plan for the Prevention and Control of NCDs (2013–2020) and include the three broad public health strategic domains for reducing disease burden, namely: a) prevention and health promotion, b) diagnosis and treatment, and c) monitoring, surveillance and research. The fourth priority area, governance and coordination, was identified within the Strategy as a particular area requiring strengthening, and as critical to accelerating national NCD prevention and control efforts. Currently there is a gap with implementing this planned initiative as document analysis indicated this has not yet been done, and this is further shown in the subsequent chapters.

4.4.1 Botswana's NCD Strategy: priority areas and objectives

In Botswana, the NCD response strategy and its goals and objectives are addressed through various policy documents, notably the 2018 Botswana Multisectoral Strategy for the Prevention and Control of NCDs, but also the National Health Policy, the National Development Plan 11, and the Revised Policy on HIV/AIDS. The 2018 Botswana NCD Strategy highlighted the importance of involving all government sectors, including health, foreign affairs and international cooperation, justice, finance, education, agriculture, trade and industry, youth, gender, sport and culture, labour, home affairs and defence, and the importance of including civil society organizations, the private sector, academia, and developmental partners.

The Botswana NCD Strategy specifies the roles and responsibilities of all ministries and non-government actors in the implementation of programmes, including specific contributions and commitments towards the achievement of national NCD goals and targets. The common NCDs in Botswana listed in the NCD strategic plan include chronic respiratory diseases, cardiovascular diseases, cancer, diabetes and mental illness. These diseases contribute significantly to the morbidity and mortality disease burdens arising from NCDs in the country. The four priority areas, their corresponding strategic goals and objectives, and specific national responses, are described below.

Priority Area 1. Primordial prevention and health promotion

The primary goal here is to reduce the harmful use of alcohol and tobacco use through health promotion and educational awareness campaigns. This is intended to be achieved by raising public awareness and community mobilisation. Community mobilisation at grassroots level is seen as a tool that can help to create effective structures to respond to NCDs and risk factors. As an endeavour to fulfil this mandate, the National AIDS and Health Promotion Council (NAHPA) was transformed in 2019 with the primary mandate of carrying out national level NCD prevention coordination and health promotion in relation to NCDs. Despite these plans, mobilising the community has been the biggest challenge as there is no clear roadmap of what the country intends to do. Coupled with this is the failure to mobilise grassroots organisations as relevant stakeholders, while at the national level health promotion and awareness are not clearly coordinated. The following focuses discussion on objective 1, tobacco use.

Objective 1: Tobacco use: from global to national regulations

In an effort to address global tobacco use, the WHO Convention developed a global control framework for tobacco use to advance national and international efforts. As an endeavour to enhance global tobacco control, the 56th World Health Assembly in May 2003 unanimously adopted the WHO Framework Convention on Tobacco Control (FCTC). The key provisions of the framework include a comprehensive ban on tobacco advertising, promotion, and sponsorship, and a ban on misleading descriptors intended to convince smokers that certain products are safer than standard cigarettes. The FCTC also encourages countries to implement smoke-free workplace laws, address tobacco smuggling, and increase tobacco tax. The FCTC came into force on February 27, 2005. Further ratification or legal equivalents (acceptance or approval) continued over the next four years.

The document review illustrates that the Government of Botswana long recognized and accepted the need to sensitize its population to the harmful effects of tobacco. The country launched its first World No Tobacco Day on April 7, 1988, marking the beginning of an intensive anti-tobacco campaign. Since then, World No Tobacco Day has been held annually on May 31. The commemoration of World No Tobacco Days together with other educational programs has contributed to sensitizing the population about tobacco products and their harmful effects on

health. As a result, in 1992, the country developed a comprehensive tobacco control programme as well as the first law on tobacco and tobacco products, the Control of Smoking Act (CSA). The intention of this Act was to control smoking in enclosed public places, including licensed premises, government and private offices, health institutions, public transportation, and passenger lounges. The 1992 CSA also prohibited tobacco promotions and advertising. The Act also prohibited publication by persons or arrangements for any other person to publish tobacco advertisements in Botswana. The legislation also prohibited tobacco advertising and the sale of tobacco products to persons under 16 years of age. To ensure smooth implementation of its provisions, the Act also established a committee whose primary role was to advise the Minister of Health and Wellness on all matters related to tobacco smoking. Since 1992, the direct and indirect advertising of tobacco products has not been permitted in Botswana. All tobacco billboards were removed, and no advertising was allowed on the print media, radio, or television. This was followed by a legislative framework at the workplace, as discussed below.

In 1997, a major campaign to create smoke-free workplaces was launched. It comprised training managers in workplaces on how to develop workplace smoking policies and sensitizing them to the importance of protecting non-smokers from the harmful effects of tobacco. The documents also indicate that there is no data specific to Botswana on the relationship between tobacco advertising and tobacco consumption. The current concern is cross-border advertising, which cannot be addressed by national legislation alone. Although there are no tobacco manufacturing industries in Botswana, there are several sales agents for different brands of tobacco. Before the advertising ban policy was introduced, these agents were responsible for advertising products in the country, including efforts to ensure that their products were advertised and displayed in an attractive and visible fashion in supermarkets and other retail outlets. As soon as the advertising ban came into force, all advertisements and attractive displays of tobacco products were removed from these locations. While CSA played a major role in the control of smoking, particularly in restricting smoking in public places, reducing tobacco sales to persons under age 16, and banning tobacco advertising, it was still limited in scope. In 2021 the Tobacco Bill was presented in the country to replace CSA, as discussed below.

According to reports, the Africa Tobacco Control Alliance 2021, the and the government legislative framework for the Tobacco Bill 2021, the Tobacco Control Act 2021 was passed to adopt a tobacco control law compliant with the WHO Framework Convention on Tobacco Control (FCTC). The new 2021 Act repealed the Control of Smoking Act of 1992, and is the primary tobacco control law in the country. The new law established a multi-sectoral Tobacco Control Committee. Those who are engaged directly or indirectly with the tobacco industry cannot be appointed as members of the committee. The Act governs several aspects of tobacco control, including, but not limited to, licencing, the ban on smoking in public or enclosed areas, a ban on retailers displaying cigarettes, and prohibition of sale to or by persons of the age of 21.

The Act provides for four types of licences: tobacco manufacturing, tobacco importing, tobacco exporting, and tobacco sales licenses. No sale of tobacco or tobacco products is permitted without a licence which is valid for a period of 1 (one) year from the date of the issue. Furthermore, it is an offence to purchase tobacco or tobacco products from an unlicensed vendor. The Act provides the following sanctions.

- a manufacturer who sells any tobacco product without a licence will be liable to a fine of BWP 750,000 or to imprisonment for a term not exceeding a period of 4 (four) years or to both;
- a wholesaler, importer or exporter who sells any tobacco product without a licence will be liable to a fine of not more than BWP 5000 or to imprisonment for a term not exceeding a period of 6 (six) months or to both;
- In addition to the fines and imprisonment, the Tobacco Control Committee may seize or destroy any tobacco or tobacco products sold or manufactured without a license.

Objective 2: Reducing harmful use of alcohol

Reducing the harmful use of alcohol was addressed by the Presidential Alcohol Levy 2008 and Alcohol Policy 2010. The Alcohol Policy 2010 and the Levy are discussed in detail in this chapter (under section 4.4.4 Botswana Alcohol Policy and the Presidential Alcohol Levy). The analysis demonstrates that although the government stated that the industry would not be involved in the design and development of the draft of the Alcohol Policy, research presented in academic

publications shows that the alcohol industry *was* involved in the development of alcohol policy in the country. Similarly, (106) presenting case studies of draft national alcohol policies in four sub-Saharan African countries (Lesotho, Malawi, Uganda, and Botswana) suggest that the alcohol industry played a significant role in their development, resulting in proposed policies that served the industry's interests. It is also indicated that the WHO played an instrumental role in providing technical support and advisory role as discussed below.

The WHO has defined "Best Buys", including enacting and enforcing bans on alcohol advertising, restricting access to alcohol, and increasing alcohol taxes, and these have been adopted and adapted in Botswana in one or another, as discussed in detail in Chapter 6. The country's Alcohol Policy has adopted some of the WHO guidelines to address the harmful use of alcohol. The document analysis suggests that the country developed its own alcohol policy and introduced an alcohol levy before it was enacted by the WHO. This was considered controversial because it was rapidly enacted, without adequate consultation with stakeholders as discussed in Chapter 6.

Priority Area 2: Primary prevention and early detection

The document analysis indicates that this priority area focuses on early detection and provision of quality, people-centred services that begin at the PHC level. It focuses on the following objectives, which are premised on the prevention and early detection of disease through establishing NCD interventions at national level and PHC level.

Objective: Establishing policies

This objective forms an integral part of the objectives already discussed under Priority Area 1 above, and the country's NCD Strategy, National Health Policy, and other documents supported at many levels, including key reports and the establishment of the National AIDS and Health Promotion Council (NAHPA) (formally NACA). NAHPA is responsible for coordinating the national prevention response for NCDs and is mandated to carry out health promotion and educational awareness. The curative aspects and clinical guidelines are the responsibility of the MoHW. For instance, the Botswana NCD Strategy indicates that it intends to have 80% cervical cancer screening coverage by 2023, and to reorient and strengthen

health systems to deliver timely, standardised, appropriate and patient-centred care.

Clinical guidelines on hypertension, breast cancer, and diabetes are, in theory, developed by the MoHW, although Chapters 5 and 6 present findings indicating that some of these are not available, leading to some CBOs developing their own guidelines. The Botswana NCD Strategy also aims to provide a national multi-sectoral approach to address the NCD burden through the involvement of sectors outside of health, and also aims to extend this to decentralized level structures such as DMSACs, VMSACs and PHC units. Following the launch of the Botswana NCD Strategy in 2019 by His Excellency Dr. Mokgweetsi Eric Masisi, a new structure was set up to replace the National AIDS Council and was renamed the National AIDS and Health Promotion Council (NAHPC) Chaired by the Vice President with NAHPA serving as its Secretariat housed at the Ministry of State President to ensure political support.

The document review shows that the Central Medical Stores (CMS) is responsible for the supply of essential drugs at the national and sub-national levels, including for those living with high blood pressure, diabetes and CVD. However, there are frequent stockouts of essential drugs, discussed in Chapters 5 and 6. The revised government policy on drugs led to the establishment of the Botswana Medicines Regulatory Authority (BOMRA), which is responsible for ensuring the safety, efficacy, and quality of medicines and related substances, including both human and veterinary medicines, medical devices, and cosmetics in Botswana. BOMRA has three key areas: Product Evaluation and Registration, Licensing and Enforcement and Pharmacovigilance and Clinical Trials. Product Evaluation and Registration ensures that all medicines and related substances manufactured or imported into or exported from Botswana are registered and conform to established criteria of quality, safety, and efficacy. Licensing and Enforcement are responsible for ensuring that the personnel, premises, and practices employed to import, export, manufacture, promote, procure, store, distribute, and sell medicines comply with the defined codes of practice and other requirements. Pharmacovigilance and Clinical Trials are responsible for monitoring and reporting adverse reactions to medicines, and conducting post-marketing surveillance to ascertain the quality, efficacy, and safety of medicines circulating in Botswana.

Priority Area 3: Promoting research, monitoring and surveillance

The primary goal of this Priority Area is to build capacity for innovative and policy impacting research and to perform monitoring, surveillance and research to measure the burden of disease and provide effective and efficient responses. There seems to be no actual policy in place driving the promotion of such research, although the MoHW floated research proposals on Post COVID-19 and future pandemic preparedness. The tobacco unit at the MoHW has also developed research proposals to study the harmful use of tobacco. Similarly, NAHPA has also created a research proposal for various projects, including the DREAMS HIV/AIDS project. The Government of Botswana has also recently set up an institution responsible for national research funds, but not specifically focused on public health research. Thus overall, there appears to be a lack of national research funding streams that sustainably support research on NCD prevention and control in the country. Some studies undertaken have been mainly clinical, for example addressing NCD comorbidities, and this study is the first of its kind in the country. A series of NCD-related surveys has been undertaken with the financial and technical support of international agencies.

Priority Area 4: Promoting governance, partnerships and leadership

The document analysis indicates that this priority area's focus is to accelerate the country's response to NCDs through strengthened national prioritisation, coordination, multi-sectoral action and partnerships. Key to this is the milestone to achieve a 25% increase in total funds spent on NCDs across sectors by 2023, as well as to strengthen multi-sectoral coordination and participation to align stakeholder support for the national response at all levels, and ensure that 100% of ministries, districts and parastatals include this in their annual work plans for successful implementation of the strategy.

The Botswana NCD Strategy clearly has a multi-sectoral approach, as advocated by global policy documents, and similar to that used in the response to HIV/AIDS, which drove the transformation of NACA to NAHPA, and the establishment of the National AIDS and Health Promotion Council, thus adopting a similar structure that was used by the National AIDS Council (NAC). These developments signalled government's commitment and political will by health sector leaders to tackle NCDs. However, the analysis indicates that no significant progress has been made

due to a multiplicity of factors, including fragmented leadership, parallel governance structures, and a siloed approach, and still no clear guidelines from the MoHW or NAHPA. The response has been haphazard with a clear lack of direction. At the sub-national level, the NCD response has been weak, with no specific budget line, medicine stockouts, and lack of trained human resources, leading to chaotic task shifting and worsened quality of care.

Furthermore, with respect to the tobacco control legislation discussed under Priority Area 1 above, as expected from the tobacco control community, the 2021 bill was targeted several times by entities that are undoubtedly tobacco industry allies, to prevent it from being passed. Members of Parliament rejected the bill, while entities such as Business Botswana, the largest private business advocacy body in the country, called on the Minister of Health to withdraw it from parliament. British American Tobacco Botswana argued that "livelihoods will be impacted by cigarette sales in minimum packs of 20's". Some media organs requested that the government of Botswana suspend the process of formulating this law. They advertise tobacco products and fully consult with the tobacco industry.

Despite this pushback, the tobacco control actors remained steadfast and did not change their position. It was reported that despite the pushback from the tobacco industry, the government, WHO and civil society joined forces to endorse the bill. The tobacco control actors were credited for their resilience against tobacco industry efforts to weaken the bill and even attempts to prevent it from being adopted. Owing to the irreconcilable conflict of interest that exists between the industry and public health priorities, the FCTC recommends that the tobacco industry be excluded from all discussions related to the formulation of tobacco control policies. As a party to the FCTC, Botswana had an obligation to abide by this requirement.

4.4.2 Strengths of the Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs

The Botswana NCD Strategy and a number of other policies related to alcohol and tobacco control have the potential to strengthen the implementation of the country's National Health Policy, although with varying challenges. The presidential launch of the NCD Strategy in 2019 demonstrated high-level political

commitment to the NCD response in the country and led the government to undertake numerous policy measures, particularly on alcohol and tobacco prevention and control.

Since the policy window created by the landmark UNGASS Political Declaration on NCDs in 2011, and the WHO "best buys" urging governments to establish multi-sectoral national policies and plans, the document analysis indicates that the country has made positive strides with the Botswana NCD Strategy and by including NCDs into the National Development Plan in 2019. However, the document review also indicates that progress in implementing and adopting the multi-sectoral approach in response to NCDs has been slow.

As discussed earlier in the chapter, the development of the country's Multi-sectoral Strategy for the Prevention and Control of NCDs 2018-2023 has not brought any significant improvement in the response to NCDs in the country. The milestones and targets set remain rhetorical with little action. For instance, the multi-sectoral action plans for PHC interventions for NCD services, which should cut across the continuum of care from health promotion through to prevention, early detection, and palliative care, have not been achieved. The analysis indicates that the implementation of the multi-sectoral approach is hampered by poorly resourced PHC, which means the health care system to failing with early NCD detection. Consequently, diagnosis is made late when people develop NCD complications, and at this stage, hospital care becomes a necessity, thus increasing the burden on the health care budget and worsening health outcomes.

4.4.3 Gaps in the NCDs Strategic Framework

The curative response to NCDs in Botswana is undertaken by the MoHW, and the preventive response by NAHPA, which is also responsible for health promotion at the national level. Although the Botswana NCD Strategy was developed following WHO recommendations and guidelines, serious gaps remain in the implementation process. The political willingness and support for implementation exists, but it is not supported by resources or incentives to do so, such as a sufficient budget and trained personnel, both at the national and sub-national levels. Some CBOs stated that they had to develop their own tools and guidelines as they were not available at the MoHW or NAHPA. This compelled them to work in silos in order to achieve any progress.

The document review indicates that the content of Botswanan NCD policies should be weighted towards health promotion, education, and sensitization. However, the review indicates that the bulk of the budget is spent on curative aspects of the NCD response, and not much on preventive aspects, even though health promotion and preventive measures are well known. The response to HIV/AIDS demonstrated that education is seen as key to improving the health-seeking behaviour of people, which, however, is very limited or ill-informed in response to NCDs.

4.4.4 Botswana Alcohol Policy and the Presidential Alcohol Levy

Following the brief description of the 2010 Alcohol Policy and 2008 Presidential Alcohol Levy earlier in section 4.4.1, objective 2, this section discusses these two measures in more detail.

Various reports indicate that alcohol abuse has become an enormous public health concern globally. In the Botswana Alcohol Policy it is noted that the harmful use of alcohol is associated with increased morbidity from several NCDs, high rates of HIV infections, high incidences of gender-based violence, especially intimate partner violence, increased road traffic fatalities, and other severe socio-economic consequences for drinkers, their households, and wider communities. The harmful use of alcohol therefore has negative health consequences, but also inflicts significant social and economic losses on individuals and society, which compelled the government to respond by developing levies and policies.

As an effort to curb the harmful use of alcohol, in 2008, the Government of Botswana imposed a 30% tax levy on all alcohol products to try to deal with problematic drinking in the country. The purpose of the 2010 Alcohol Policy is not to deny people the right to drink alcohol, but rather to encourage moderate alcohol consumption. The policy sought to achieve this through public education and information dissemination on the dangers of alcohol. Furthermore, the policy includes measures such as restrictions for on or off premises sales as well as emphasis on the national minimum age for buying alcohol or entering alcohol premises. However, document analysis illustrates that the government of Botswana came up with a national alcohol policy after taking into consideration both the rights of individual to drink alcohol, while at the same time seeking to safeguard vulnerable groups, especially the youth. The levy was initially set at 70%

but was later reduced to 30%. Over and above the tax increase, hours of operation for drinking outlets were drastically reduced and selling alcohol from homes (shebeens) was outlawed.

The implementation of tax levies and alcohol regulations occurred concurrently. Different reports and academic papers show that it is important to note that there is no evidence of any scientific study that guided the implementation of the tax increase and its associated regulations. The government did not commission an empirical study to guide the implementation of these reforms. Furthermore, reports show that even after the start of implementation, no nationally representative study has been conducted to assess the impact and effectiveness of the levy. The reforms introduced led to a drastic reduction in operating hours for entertainment areas, including bars. According to the regulations, the bars opened from 2pm to 10pm from Monday to Thursday (a reduction from the previous operating time of 9am to 11pm). For the weekend (Fridays and Saturdays), the new hours were from 12 noon to 11pm (previously 9 am to 11pm). On Sundays and public holidays, the hours were reduced to 3 pm to 10 pm (previously 11 am to 11 pm).

The introduction of the 2008 Levy and the associated regulations received pushback from the alcohol industry and claims that the tax levy implementation threatened to harm its profit margins. The document review highlights that the industry's argument was that the levy was just spontaneous and was introduced without any form of consultation with the industry and relevant stakeholders including the MoHW. Document analysis also indicates that everyone was caught by surprise, and no one could challenge the decision of the former President Ian Khama as he was extremely feared; hence the labelling of his actions as "Jihad" and his actions being viewed as "the war on fun".

Merits of the Alcohol Policy and Levy

Several documents, including reports, were used to describe the drivers of the 2010 Alcohol Policy formulation and how it impacted the response to NCDs and risk factors in the country. These show that little has been achieved, as discussed in detail in Chapter 6 of the thesis. The main objectives of the Alcohol Policy were to reduce alcohol consumption and set liquor regulations and trading hours, however, the study findings (Chapter 6) show something to the contrary. The

intended objectives of the levy were also geared towards establishing rehabilitation centres, but the study findings (see Chapters 5 and 6) show that these are just rhetorical statements, and nothing has been achieved to establish rehabilitation centres.

Demerits and constraints of the Alcohol Levy and Policy

Reports, newspaper articles, and policy documents indicate that despite the introduction of the Alcohol Policy and the Alcohol Levy, harmful use of alcohol is still rife in the country. Furthermore, the BIDPA report also stresses that the introduction of the Alcohol Levy did not achieve its intended outcomes as more people continued to consume alcohol. The report stressed that this is linked to both alcohol's addictiveness, and historical or cultural factors, as alcohol consumption has been part of Botswana's cultural festivals, weddings, and other traditional ceremonies. Documents reviewed also indicate that while the Government of Botswana stressed that the industry was not involved in the drafting of the country's Alcohol Policy, reports and academic publications show something to the contrary. A closer look at Botswana's alcohol policy, for example, reveals similarities to that of Lesotho, Uganda, and Malawi in terms of structure and wording. Academic papers show that the South African Brewer (SAB) Millier, the largest conglomerate, was instrumental in the development of alcohol policy in Lesotho.

4.5 Botswana National Health Policy Framing and the NCD Response

The Botswana National Health Policy is discussed in this section in the context of how the policy document gives a clear direction for the development of the health sector in the country and health sector responses to policy measures. Furthermore, it discusses how the Botswana National Health Policy serves as a guide to the strategies and programmes in the health sector and its response to the double burden of disease (having to respond to communicable and non-communicable diseases). The Botswana National Health Policy's uses a title 'Towards a Healthier Botswana', implying that the provision of health services is not just merely curing the sick, but also promoting healthy lifestyles to prevent diseases and promote wellbeing for the population. Despite all the policy intent specified in the National Health Policy, however, it remains generic in that it is not linked to the budget nor to the response to NCDs and risk factors in the country. The National Health Policy

incorporates the WHO's Health System Framework (also known as Building Blocks), (107) as a key guide for how the country's health system intends to provide health services delivery, with specific plans for each of these WHO building blocks. The internationally accepted six operational building blocks that structure the National Health Policy are:

- Leadership / Governance
- Health Care Financing
- Health Work Force
- Medical Products, Technology
- Information and Research
- Health Service Delivery.

The WHO building blocks are a useful reference point for national policymakers, as they provide a common language as well as accepted conceptualisation underpinning the discourse on health systems. However, the way the building blocks are used in the Botswana health policy document looks primarily as if the material has been cut and paste from global guidelines. And while there was presumably a positive intent to adopt and adapt the WHO six building blocks, little or no achievements have been made in this regard.

The National Health Policy sees the building blocks as tools for planning, funding decisions, and establishing priorities, but does not give clear detailed guidelines as to how the policy intends to achieve the stated milestones and goals against each building block. Furthermore, although the Policy intends to provide a platform for well-coordinated planning, financing, monitoring, and evaluation, closely matching each block, the document review shows something to the contrary. The Policy also intends to provide for stakeholder involvement in the continuous monitoring of the implementation of the policy, as well as its future revision, but again the document review also shows something to the contrary.

The National Health Policy indicates that the two-tier (decentralised) health system envisages that the health system operates with shared authority across each tier of government and ensures that the management, delivery, and financing of health services are the responsibility of the two tiers of government. The National Health Policy indicates that promoting access to PHC interventions for NCDs is highlighted in the Botswana Multisectoral Strategy for the Prevention and Control

of NCDs, and stresses that it is paramount to provide NCD services across the continuum of care from health promotion through to early detection, care, and palliative health care. However, while the National Health Policy intends to extend its coverage of NCD services to PHC, as set out in the Botswana NCD Strategy, there are discrepancies such as inadequate budgeting and limited trained human resources to respond to NCDs, which are not aligned to the actual implementation plans set out in both of these documents. There is also disparity between the national and sub-national level, and rural and urban divisions, in the response to NCDs, as discussed in Chapters 5 and 6. Reports indicate that PHC is poorly resourced in the country, hampering access to early detection of NCDs leading to late detections and diagnosis of NCDs.

While the National Health Policy document indicates policy intention to train and develop the health workforce to enable it to respond to NCDs, it is not linked to the NCDs response.

4.6 The Role of The Essential health service package (EHSP) in NCD response in Botswana

This section discusses the Essential Health Service Package (EHSP), which was developed taking into consideration the recommendations of the WHO Package of Essential NCD interventions, with the primary aim of helping to improve the coverage of appropriate services for people with NCDs in primary care settings. The package of essential NCD disease interventions for PHC was first published in 2010 and is a prioritized set of cost-effective interventions that can be delivered to acceptable levels of quality of care.

In 2013, the MoHW, in collaboration with the University of Botswana, initiated the adaptation of the WHO package for Botswana, leading to the endorsement of the country's first national PHC guidelines for adults in November 2016. These guidelines include screening, risk stratification, and management of diabetes, hypertension, and asthma, and screening for broader management of common clinical complaints and preventive care in adults. In addition to evidence-based treatment decision support for healthcare providers, the guidelines also emphasize the promotion of patient self-management through individual counselling by a nurse and a dietician, as well as group education, defaulter tracing, and strengthening coordination of care.

According to document analysis, WHO's Package of Essential Non-communicable Disease Interventions (WHO PEN) for PHC in low-resource settings provides evidence-based clinical guidelines to improve access to and quality of NCD services delivered at PHC facilities, while bolstering the universal health coverage agenda. The documents discussed in this section are essential to provide an understanding of the set-up of the health system and the mechanisms that are in place for health care promotion and preventive, curative, and rehabilitative mechanisms in the country. There is a global and national consensus that using the PHC system, is key in addressing non-communicable diseases.

Document analysis indicates that In Botswana, the EHSP was developed to promote, prevent, cure, and rehabilitate the country's entire population and the care can be provided through public, private, or a combination of public and private facilities. The concept of the EHSP is that all the services in the package should be available as an integrated whole, rather than piecemeal, as individual services, or only through vertical programmes. It also implies that all key stakeholders will have the opportunity to contribute their ideas and experiences.

ESHP consists of four components: (a) sexual and reproductive health (SRH), (b) child health, (c) communicable diseases, (and) (d) non-communicable diseases. In addition, the provision for PHC delivery of NCD services was included in the country's 11th National Development Plan (2017–2023). Before 2016, there were no national clinical guidelines for NCDs. Adults presenting to primary clinics with a major NCD, such as diabetes, hypertension, cardiovascular disease, chronic respiratory disease, and cancer, were managed and referred inconsistently, depending on the training of individual providers or whether the provider used international professional guidelines.

According to the EHSP document review, the EHSP management of NCDs includes the detection, screening, and treatment of these diseases, and providing access to palliative care for people in need. NCD interventions can be delivered through PHC to strengthen early detection and timely treatment. The key priority areas and areas of coverage for EHSP are:

- Financing mechanisms and innovative economic tools
- Early detection, prioritizing, high impact interventions

- Train the health work force and strengthen the capacity of health systems at PHC level to address the prevention and control of NCDs
- Improve technologies and essential medicine
- Develop and implement a palliative health care policy.

EHSPs define the health interventions that governments are committed to provide and make accessible to the entire population. The content has not been comprehensive; not all health needs will be met by the EHSP. The range of interventions is dependent upon the financial resources available; that is, the health expenditure government is prepared to commit to the EHSP.

The key issue here is that the response to NCDs using the PHC model is guided by the WHO package of essential NCDs clinical guidelines and not by nationally developed ones that may be better in ensuring access to quality services. This demonstrates the overreliance of national governments on WHO to provide tools and guidelines for responding to NCDs at PHC facilities and sub-national level. As a result of that, the document review indicates that this has led to a host of pitfalls, including poor infrastructure and lack of trained human resource capital with no budget for the PHC level to effectively provide access to quality NCD service delivery. There is considerable inefficiency in resource allocation. A disproportionate share of resources is allocated to secondary and tertiary sectors, where the costs incurred are often excessive in terms of the benefits achieved. Similarly, low workforce productivity, lack of essential supplies, especially essential drugs, as well as low levels of utilization, especially at PHC facilities, also result in further inefficiency.

4.7 National Policy on Mental Health

The National Policy on Mental Health provides a framework for incorporating the objectives of the mental health programme into existing general healthcare services, and it is to be implemented through the PHC strategy. The policy provides the basis for an increase in resources to expand and improve current mental health services and facilities. The policy recognizes that mental health is an integral part of health and a right for each individual and care should span different diseases including NCDs. Therefore, this policy is geared towards improving the provision and delivery of comprehensive mental healthcare services.

4.8 Conclusion

The document analysis indicates that in Botswana, before 2016, the only national policy instruments related to NCDs that were in place were the Alcohol Policy, Tobacco Policy, Nutrition Strategy, Essential Health Services Package, and Botswana Public Health Act, which did not comprehensively address the response to NCDs. This chapter identified and reviewed the policy documents, reports and newspaper articles relevant to the response to NCDs and risk factors in Botswana. The review aimed to gain a greater understanding of the breadth and depth of the country's response to NCDs, and of the actual steps in the policy process leading to the development of the NCD strategy in the country.

The chapter first discussed the global policy frameworks on NCDs, and the political window given to national governments by the UNGASS Political Declaration on NCDs in 2011, which called to the international community and national stakeholders to raise awareness and launch an effective response to NCDs in their respective countries. It shows that the cornerstone of the national policy response for the prevention and control of NCD in the country was the UN Political Declaration on the Prevention and Control of NCDs 2011, which established the policy window, the call for action, and a set of recommendations for adoption.

Document review analysis indicates that the Government of Botswana made a concerted effort to respond to NCDs following the UNGASS Political Declaration 2011 and included NCDs for the first time in the National Development Plan Eleven (11) in 2009. Document analysis also indicates that NCDs were included for the first time in the 2019 government national budget and its allocation to the MoHW, although minimally.

However, the WHO Progress Report 2022 reports that the country is still lacking in its response to NCDs. Some of the reasons indicated in the WHO report were insufficient budget allocation for NCDs in the country at national level as well as lack of trained human capital to be able to deal with the response to NCDs. Document review also indicates that despite measures to better regulate alcohol sale and use, the industry's main interest remains on profit maximisation and it has resisted attempts by government and civil society for regulation. These tensions are examined in Chapter 6.

The Government of Botswana, through the MoHW, was instrumental in the development of the 2018 Botswana Multisectoral Strategy for the Prevention and Control of NCDs in the country, which was timely. The Botswana NCD Strategy is supposed to catalyse a multi-sectoral response in tandem with health systems strengthening, particularly at the PHC level, but this has not materialized as further discussed in Chapter 5. The objectives of the Botswana NCD Strategy 2018-2023 have not been adequately implemented and analysis in Chapters 5 and 6 indicates that unlike in the response to HIV/AIDS, there has been no policy champion to spearhead a robust response to NCDs, and there has been little investment by the country on PHC to enable it to effectively respond to NCDs. Furthermore, the Botswana NCD Strategy and the relevant policies developed towards the provision of health services delivery are not linked, therefore there is no supporting budget for NCDs and a lack of human resources trained to diagnose and manage complex NCDs effectively. There is little apparent prioritization of NCDs in research funding, and there are high levels of stockouts for NCD medicines, especially for diabetes and high blood pressure.

Document review indicates that the Botswana NCD Strategy 2018-2023 resulted in the formation of the National AIDS and Health Promotion Council (NAHPC) to oversee the planning, guidance, monitoring, and evaluation of the implementation of the integrated NCDs response with the active involvement of sectors outside of health. Notably, there is strong emphasis on the importance of involving all policy actors, including within health, education, local government and rural development, agriculture, trade and investment, the private sector, civil society organizations, UN Agencies, and others. Despite these intentions, this is yet to be done, as the national response to NCDs has been undermined by a lack of coordinated action as discussed in the subsequent chapters.

The document review also suggests that although national policy developed an integrated approach to addressing NCDs and risk factors, as stressed in the Botswana NCD Strategy 2018, there remain some gaps and challenges as the country's response to health issues remains predominantly focused on HIV/AIDS, as discussed further in Chapters 5 and 6.

With regards to the harmful use of alcohol and tobacco, these are addressed by the Alcohol Policy and Alcohol Levy, and the Tobacco Control Act 2021 (which

replaced the Control of Smoking Act). Although there are considerable gaps and the country has received a backlash from industry for its policy and regulations on the harmful use of alcohol and tobacco use, the country is considered to be making good progress in the response to the harmful use of alcohol and tobacco, in line with the WHO Framework Convention on Tobacco Control and the three Dimensions on Harmful Use of Alcohol. There is a clear indication that although the country is faced with some challenges, it is making some progress in responding to tobacco use, by ensuring a ban on advertising and creating smoking-free public spaces. The WHO Progress Report 2022 on the country's response to tobacco use, however, indicates that smoke-free policies, as well as large graphic health packaging, have not yet been achieved.

Country reports also indicate significant progress in the implementation of the control of smoking measures, first through the Control of Smoking Act (CSA), then the Tobacco Control Act. Furthermore, it also indicates concerted efforts and participation of stakeholders in implementing these policies, as well as political willingness to effectively support the tobacco ban. However, although the ban on advertising from the industry has been partially achieved, the industry has attempted on numerous occasions to push back and has gone to the extent of underground advertising, and promoting the alternatives of vapes and hubbly bubblies, especially to the youth.

Overall, the document review reveals a lack of implementation action on NCDs, especially the promotive aspects at the sub-national level, where there is confusion even over roles and responsibilities. There is also a lack of coherence between national and sub-national level structures and policies. There is a lack of trained human resources to respond to NCDs in the country, including a deficiency of physicians and trained nurses specialising in complex NCDs both at the national and sub-national levels, and for example also including oncologists and oncologist nurses. A larger number of Batswana physicians are working in the capital city of Gaborone, while rural areas suffer extreme shortages leading to the placement of foreign physicians from Cuba, Zimbabwe, and DRC Congo

Drawing on Shiffman's framework we can examine actors, ideas, context and issue characteristics through the documents, reports and newspapers reviewed. They show that the policy context was slow to evolve for NCDs, despite the window of

opportunity provided by the 2011 UNGASS Declaration on NCDs. The guiding actors are the MoHW and the National AIDS Control Programme (NAPHA), the latter repurposed to take on responsibility for NCD prevention. The fragmentation of roles and responsibilities between MoHW and NAPHA and the lack of alignment between the National Health Policy and Botswana NCD Strategy, in terms of key health systems functions, have meant there is a lack of dedicated budget or trained workforce for NCD service delivery and risk prevention actions. This stands in contrast to the streamlined and well-resourced response to HIV/AIDS and provides a less-than-optimal policy context within which implementation must occur. It is to actor perceptions and experiences of the policy development and implementation that I now turn in Chapters 5 and 6, looking first at the multiple government actors (Chapter 5) then at non-government actors of all kinds (Chapter 6).

Chapter 5: Government Actors (Guiding Institutions) and their Networks

In this chapter, I first identify and map the government actors (guiding institutions) and their networks involved in shaping the dimensions of Non-Communicable Disease (NCD) policy in Botswana. Subsequent sections then examine each of the key government actors involved in NCD policy development, coordination and implementation, and how these different actors were involved in the policymaking – or unmaking – process. The formal roles and responsibilities of these key actors and guiding institutions according to their official mandates are described, and their actual incentives and actions, as manifested in practice, are examined as perceived by the respondents. Table 3 in the conclusion to this chapter provides a summary of government actors (and others), their formal roles, and the actual practices as discussed by respondents during interviews. I discuss the relationships between the actors and illustrate how they work together (or not) in developing policies related to NCDs in Botswana, the division of responsibilities, the coordination and connections, or disconnections between the actors. In section 5.2. I focus on the MoHW's roles at national level and then policy implementation issues at sub-national level, where implementation problems are discussed. In section 5.3, I focus on the reconfigured National AIDS and Health Promotion Agency (NAHPA), responsible for NCD prevention, and discuss action or inaction to integrate NCD policies and programmes into the health policy planning process. Section 5.4 discusses the role of another key ministry, the Ministry of Local Government and Rural Development. Section 5.5 considers questions of leadership and political commitment towards NCD policy implementation.

Throughout the chapter, factors hindering implementation related to questions of leadership and commitment, incentives and resource constraints are discussed, both at national and sub-national levels. Both national and sub-national implementation responses are discussed within the context of decentralized health service delivery. Sub-national actor responses are critical to understanding how policies are operationalized and underpin service delivery at this level, and shape policy development, and these are considered in the analysis.

5.1 Actor Mapping

The following sections describe in detail each of the main actors, the nature of their involvement in NCD policy conceptualization and implementation, and their main positions and influence on the development of the policy-making process for NCDs and risk factors in the country. These roles are important in unpacking the underlying power the main actors possess and how this has shaped policymaking on NCDs and their risk factors. Actors' effectiveness or ineffectiveness in executing their roles and functions, including overseeing the structures created, are also analysed. Examining the actors' roles and mandates also helps unpack their capacity, identify strengths and weaknesses, and any constraining or mitigating factors in their NCD response. Furthermore, the structures involved in the implementation process and the extent to which the main actors exercise their power and authority were examined. The analysis draws on policy document analysis and a wide range of interviewees' perspectives on each key actor. Table 3 in the conclusion to this chapter provides a guide to each of the codes used when actors who were interviewed are cited.

The documents analysed showed that a wide range of actors were involved in the development of the Botswana Multisectoral Strategy for the Prevention and Control of Non-Communicable Disease 2018-2023 (Commonly referred to as the National Strategic Framework on NCDs, hereafter referred to as NSF-NCDs). Key government actors included the Ministry of Health and Welfare, Ministry of Local Government and Rural Development, Ministry for Presidential Affairs, Governance and Public Administration, Ministry of Finance and Development Planning, and the National AIDS and Health Promotion Agency (NAPHA). Other key actor categories were civil society (NGOs, CSOs, and CBOs), the private sector, WHO, UN agencies, and development partners.

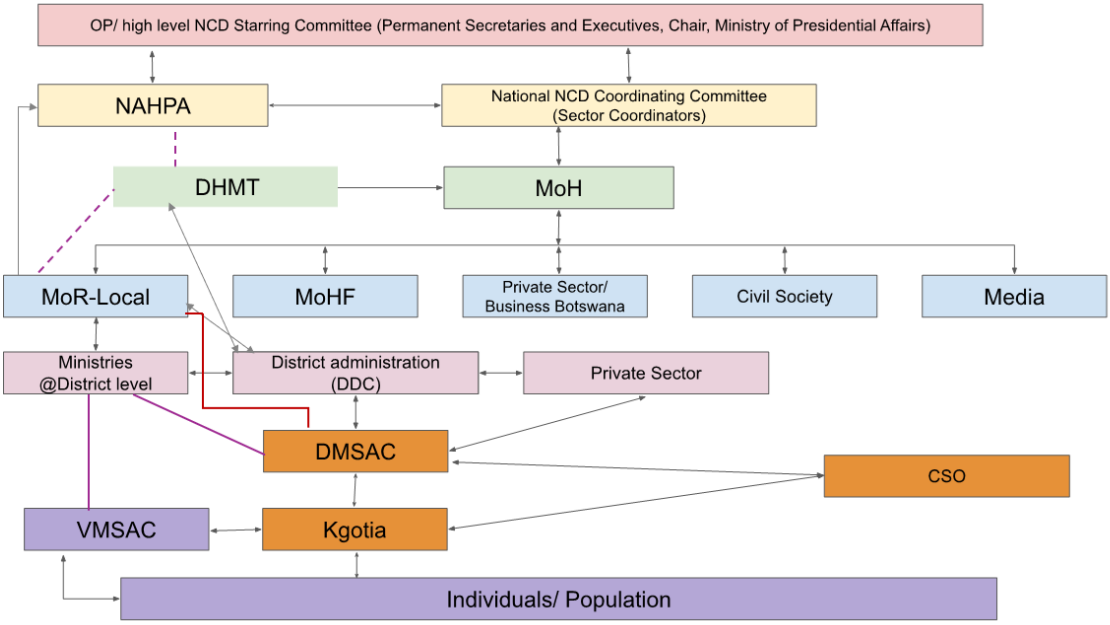
Figure 5.1 below shows a stakeholder mapping of the main government actors and their relationships – as specified in the policy documents. Their perceived and actual roles are described in depth in subsequent sections. The figure demonstrates that the NCD response in Botswana is led by the Ministry of Health and Wellness for curative aspects, and by the NAHPA for preventive or promotive aspects, while the implementation and progress of policies in the response to NCDs and risk factors is the responsibility of a high level steering committee which

is comprised of Permanent Secretaries and Executives and is chaired by the Vice President housed at the Ministry of State President. NAHPA also serves as the secretariat of the National NCD Coordinating Committee (NCCC). This committee is multi-sectoral and, notably, has adopted the same structure used earlier in the response to HIV/AIDS, including various government ministries, the private sector, civil society organizations, and UN agencies. The arrows pointing to each other (solid lines) in Figure 1 illustrate the formal relations between institutional actors and non-institutional actors and their inter-connectivity in the making or unmaking of the NCD strategy, while the dotted lines depict informal relationships. The colouring in Figure 1 has no significant bearing on the formal and informal relationships of the actors. Figure 1 also maps the relations of actors through the decentralized levels from the national to sub-national levels.

Figure 1 shows that at the district level the Ministry of Local Government is responsible for decentralized governance and service delivery including environmental health, and it is formally connected to the MoHW and NAHPA, and informally connected to the District Health Management Teams. Figure 1 also illustrates that the Ministry of Local Government and Rural Development connects informally with district-level structures such as the District Multisectoral AIDS Committees (DMSACs) and Village Multisectoral AIDS Committees (VMSACs), through the District Administration led by the District Commissioner. The District Commissioner also chairs the DMSAC with District AIDS Coordinators (DAC) serving as the secretariat of these multi-sectoral structures. Furthermore, Figure 1 also illustrates that the Ministry of Local Government and Rural Development connects with other non-institutional actors at the subnational level through DMSACs and VMSACs. The institutional and non-institutional roles are discussed extensively in both this chapter (in relation to government actors) and Chapter 6 (in relation to other actors).

Figure 1 indicates that the structures of NCD policy governance are both top-down and bottom-up. However, the study findings reveal something to the contrary with decision-making processes being mainly top-down. Subsequent sections will now discuss the reality of decision making by each key government actor.

Figure 1: Stakeholder Mapping: Formal and Informal Relationships



5.2 The Ministry of Health and Wellness in the Response to NCDs: Roles, Responsibilities and Realities

This section discusses the roles and responsibilities of the Ministry of Health and Wellness in response to NCDs and risk factors in the country. The structures and operations of the Ministry of Health and Wellness are considered in order to identify its commitment and challenges in the response to NCDs and the risk factors of how the response is coordinated from the national to the district level (sub-national). It first examines the development of the Botswana Multisectoral Strategy in the Prevention and Control of NCDs, which was facilitated and operationalized by the Ministry of Health and Wellness, identifying the institutional and non-institutional actors that participated in the development of the Strategy on NCDs and why. It then examines the relationship of the Ministry of Health and Wellness with Ministry of Local Government and NAHPA at national level and District Health Management Teams (DHMT) at the subnational level and discusses the process of the NCDs response at this level. Taken together, this section seeks to examine the evidence of the commitment of the Ministry of Health and Wellness in the response to NCDs as a steward, how it has implemented and coordinated the response, and how it has helped to support decentralization and an effective sub-national response to NCDs.

5.2.1 National level coordination

The study findings show that the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs follows several global HIV and NCD strategies that encourage the integration of HIV and NCD management. The Botswana Multisectoral Strategy for the Prevention and Control of NCDs is geared towards incorporating NCDs into HIV/AIDS structures and existing services. However, in practice, there has been limited action to achieve this integration.

In a group interview with three MoHW senior officials (A1 MoH3) (see Table 3 in the conclusion of this chapter for these codes), one respondent stressed that the process of developing the Multi-Sectoral Strategy for the Prevention and Control of NCDs was driven by the MoHW and was finally launched in 2019 by His Excellency President Mokgweetsi Masisi. This was particularly problematic, as some respondents from civil society organizations and the private sector felt that the process was non-consultative, for example, they were never invited to participate in the development of the NCD strategy and did not serve in the Technical Working Groups (TWAs). A civil society respondent (CI LGB) stated:

> *"We were never consulted by the Ministry of Health and Wellness when the NCDs Strategy was developed. We were just never consulted when the NCDs strategy was being developed, we did not even form part of the Technical Working Groups. Maybe they didn't think we are important.* Even our umbrella association didn't say anything about the NCDs strategy."

Nationally, the MoHW serves as a steward and is mandated with oversight and delivery of health services in Botswana. The MoHW is responsible for national health systems, including developing and implementing policies, goals, and strategies for health development and service delivery. In carrying out this function, the ministry works with different stakeholders and civil society organizations to ensure effective implementation. Document analysis and interviews confirmed that the MoHW played a pivotal role in hosting stakeholder meetings to brainstorm health policies and strategies. The MoHW provides primary healthcare (PHC) services through District Health Management Teams (DHMTs). DHMTs report directly to the MoHW and are responsible for running a network of health facilities, hospitals, clinics, health posts, and mobile stops. The

following paragraphs discuss the findings from the interviews with MoHW respondents, in terms of mandates, successes and challenges.

The three senior officials from the MoHW (A1 MoHW3) and the Assistant Minister at the MoHW (A1 MoHW4) noted that at the district level, there are District Health Management Teams that are responsible for healthcare service delivery and are expected to work with village-level structures and the District AIDS Coordinators (DAC). They are also expected to have an NCD unit, as indicated by (A1 MoHW4):

> *"At a primary care level we have now developed what you call the DHMT, the District Health Management... in this strategy is that each and every district DHMT, District Health Management Team, should have one NCD centre. The DHMT also performs coordination at the district level."*

The Permanent Secretary at the MoHW (A1 MoHW1) indicated that they have an NCD unit at the MoHW and that this unit works with the National AIDS and Health Promotion Agency's NCD unit, with the latter being responsible for the preventive and promotive aspects of NCD policies (the MoHW NCD unit is responsible for NCD curative care). According to these respondents MoHW also works directly with DHMTs which also has an NCD unit. One of the MoHW officials (A1 MoHW1) explained that the NCD unit at the MoHW focuses on the detection, screening, and treatment of NCDs and works closely with various structures at the sub-national level through District AIDS Coordinators (DAC).

The participants from the MoHW and other respondents from the Ministry of Local Government and Rural Development, NAHPA, civil society organizations, and the private sector unanimously agreed that the MoHW is responsible for the management and policy response to NCDs and risk factors in the country. The official from the MoHW (A1 MoHW1) also stressed that there is a separate department that deals with the harmful use of alcohol and substance abuse and is responsible for coordinating all alcohol-related activities in the country. The official from MoHW (A1 MoHW1) also stressed that there is a separate unit for the harmful use of tobacco.

For these Ministry of Health officials (A1 MoHW1), the establishment of the Alcohol Division signified the country's committed response to the harmful use of alcohol, other risk factors for NCDs, and NCDs themselves. However, despite this view

among the Ministry of Health officials, a different view was held by an official from the Alcohol Division, Ministry of Health (2MOHAL), who stated that there was a lack of political continuity and support in the response to the harmful use of alcohol, compared to the past political leadership. Furthermore, (2MOHAL) pointed out that compounding this problem is the ineffective Interministerial Committee on Alcohol, which is no longer functional nor effectively led, and no longer regularly meets as it used to. The official from the Alcohol Division (2 MOHAL) stated:

> *"The most difficult challenge we have right now is that, from the Alcohol Policy, there are certain responsibilities that have to be undertaken by other ministries, but they seem not to be doing it because it's not their core mandate."*
>
> *"The meetings are no longer held regularly at the Office of the President by the Alcohol Committee as they used to be. Unlike during the former President. Perhaps they feared him. He was a disciplinarian but now there is no political support, really."*

In documents, the Chairperson of the Southern African Alcohol Policy Alliance (SAAPA) highlighted the urgent need for alcohol policy improvement in Botswana in order to reduce the availability of alcohol and to make stricter rules on alcohol advertising, and it was highlighted that alcohol policies should prioritize improving the public health of Botswana, not profits:

> *"Let us use the alcohol levy to reduce the number of people buying alcohol and rehabilitating people affected by alcohol consumption."* (Priscillia Mokgadi, Chairperson, Botswana: Communities Advocate for Alcohol Policy Improvements - Movendi International).

The respondents from the private sector, from the insurance sector in this instance, indicated that lack of consultation was a serious concern and that they felt their expertise was disregarded, preventing them making a meaningful contribution (P1 BOMA). The concerns raised by this respondent that despite being an important stakeholder, the Ministry of Health and Wellness did not see the need to invite them to share their expertise and knowledge. The same views were expressed by other study participants from the private sector and civil society:

> *"The thing is the Ministry of Health and Wellness never consult us. I think they see us more as a competitor than a good partner... We are also performing much better than them."* (P1 BOMA).

> *"So one of the challenges that we are faced with is to try and find a way to help our people to be able to access the treatment without necessarily having to pay anything out of our pockets. So, you hope that someday somebody will come with some research or some inventions that can make it more affordable for people to access oncology, oncology treatment."* (P1 BOMA).

For their part, an Official from LEGAGIBO (CI LGB) stressed that:

> *"We do not have tools and national guidelines to use to assist our community. Say for instance for anal cancer and breast cancer for Lesbians. We are really challenged and have to develop our tools. NAHPA does not also assist us, both financially and with educational material."*

This in turn implies that the participants were primarily re-emphasising the importance of the crucial role that Community-Based Organisations (CBOs) can play in developing and strengthening participatory and accountable government decision-making processes.

5.2.2 Sub-national implementation

The District Health Management Teams (DHMTs) oversee delivery of integrated health services, including for NCDs, at the sub-national level, and they collect data on the prevalence of diseases and report to the Ministry of Health headquarters every six months. However, the study indicates that the revitalization of primary healthcare (PHC) has contributed to a lack of clarity about the roles and functions of the district level response to NCDs, particularly between District AIDS Coordinators (DAC) and the DHMT. The study findings suggest that this lack of clarity has also caused confusion as the District Multisectoral AIDS Committee (DMSAC) and Village Multisectoral AIDS Committee (VMSAC) are still focused on the response to HIV/AIDS and not NCDs. Compounding these problems is that there is a shortage of skilled personnel, particularly physicians and nurses trained in NCDs, for effective service delivery at the sub-national level. While NCD

integration has been attempted at the primary healthcare level it has had limited success as there is also variation in district-level integration.

The study findings show that PHC used to fall under the Ministry of Local Government and Rural Development due to decentralisation processes, and that the DHMT served as a department under district/town and city councils. In 2010, PHC was reformed leading to DHMTs moving from district or town councils to be a stand-alone institution at the sub-national level. These PHC reforms caused incoherence and disorganization within sub-national level health services delivery, with certain functions performed by DHMT and environmental health being the responsibility of the Ministry of Local Government and Rural Development through district and town/city councils. Coordination of the HIV/AIDS response was performed by District AIDS Coordinators (DAC) who fall under the District Administration office and with the District Commissioner chairing the District Multisectoral AIDS Committee (DMSAC) and DAC serving as its Secretariat. The district level and respondents from the Ministry of Local Government and Rural Development noted the same concerns.

The respondents reported that the PHC reforms had led to many overlapping roles and had caused confusion, hampering health service delivery. The PHC reforms meant that now DHMT reported directly to the Ministry of Health and Wellness and at the same time served in district or town level structures such as District Development Committees (DDC), District Multisectoral AIDS Committees (DMSAC) and Village Level Multisectoral Committees (VMSAC), whose secretariat is the District AIDS Coordinators (DAC). Equally, although DMSAC is charged with the responsibility of coordinating the response to HIV/AIDS *and* NCDs, the study findings reveal that the district-level response is still on HIV/AIDS, and not NCDs. The officials from MoHW (A1 MoHW1) stated the following:

> *"At the district level, the Ministry of Health and Wellness work through DHMT and the latter presents reports to the District Multisectoral AIDS Committee."*

The respondents from DHMT stressed that HIV/AIDS and NCD coordination at the district level are multi-sectoral, working through two committees, namely the District Multisectoral AIDS Committee (DMSAC) and the Village Level Multisectoral AIDS Committee (VMSAC). DMSAC, according to the study findings, was created as

a forum to bring together stakeholders from all sectors. DMSAC members, according to the study participants, include public health workers, non-governmental organization (NGOs), government departments, parastatals, and private industry. At the local level, the committee is managed by a District AIDS Coordinator (DAC) located within the District Administration. Each district has its own DMSAC, which is funded by the NAHPA through the Ministry of Local Government and Rural Development. District Multisectoral AIDS Committees (DMSACs) are chaired by District Commissioners/Council Secretaries.

The study participants from DHMTs stated that the DHMT participates in the multi-sectoral structures set up at sub-national level to respond to integrated health services including NCDs administered through structures such as DMSAC, VMSAC and TAC. However, these respondents indicated that although the Botswana Multisectoral Strategy for the Prevention and Control of NCDs fully stresses the willingness and commitment to respond to NCDs at national and sub-national levels, the respondents stressed that the response at the sub-national level is very minimal as the response focus is still predominantly on HIV/AIDS. Furthermore, the respondents from the sub-national level stressed that there is no budget allocation for NCDs at this level, despite the fact that NCDs were first included in the National Development Plan 11, developed by the government through the Ministry of Finance and Development Planning, and the national budget in 2019. According to the respondent from the sub-national level (D1 DH NGAM), the lack of budgeting for NCDs at this level shows lack of commitment driven by poor leadership, and the lack of a political drive to recognise that NCDs are the leading cause of mortality in Botswana that need urgent attention and policy implementation. The respondent stated the following:

> *"The response is still predominantly HIV/AIDS…. very minimal work is being done with regards to NCDs."*

A DHMT respondent (D1 DH NGAM) stated that this disorganisation and lack of effective leadership by DMSAC has led to instances where DHMT decides on the dates of the DMSAC meetings and not DAC as expected.

> *"I convene both TAC and DMSAC even though the minutes are usually taken by DAC."*

Accordingly, while the respondents from NAHPA were not specifically asked to comment on what they perceived as the weakness of the sub-national response to NCDs, they stated that the structures are incapacitated and do not have the necessary financial support and well-trained human resources and as such are no longer as vibrant as they used to be in the response to HIV/AIDS.

The respondents from the DHMT stressed that despite the disorganization of DMSAC and DAC, there is a joint planning and monitoring of delivery of healthcare services by the two ministries, that is, the Ministry of Health and Wellness and the Ministry of Local Government and Rural Development at the district level, which is guided by the Planning Handbook 2002.

The DHMT respondents stated that, as part of their mandate, they are responsible for running a network of health facilities, hospitals, clinics, health posts, and mobile stops, as well as community-based preventive and promotion campaigns. They said that each district in the country has a DHMT led by a public health specialist who is responsible for the administration and supervision of a number of public health-orientated diseases such as tuberculosis and HIV. An official from the DHMT Ngami District (NGAMI) stated that a DHMT representative also attends the DMSAC and Technical Advisory Committee (TAC), which is comprised of physicians and nutritionists at the district level. The DHMT respondents and the Ministry of Local Government and Rural Development respondent stressed, however, that VMSACs' responses to HIV and NCDs are now non-existent. dormant.

Respondents at the sub-national level, however, stated that the response at the district level currently remains for HIV/AIDS, but not for NCDs, mainly because there are a lack of action plans agreed between the national level and the sub-national level. The respondents at the sub-national level further explained that there is also a lack of trained human resources to understand how to control NCDs and stressed that much of this work is done and carried out by family physicians, who are also in short supply at the district level throughout the country. Compounding that is that trained physicians from Botswana are reluctant to be posted outside the capital city Gaborone therefore relying on physicians coming from Cuba, Zimbabwe and DRC Congo who are equally not conversant with the native Setswana language.

Furthermore, the study findings show that some districts do not have family physicians and have frequent stock-outs of medicines required for the prevention of high blood pressure and diabetes. These facilities are also unequipped and have to refer patients to the city, where the waiting period can take longer for screening and testing. Although DHMTs have a committee specifically set up for district councillors, the respondents at this level stressed that there is a lack of political support and commitment by sub-national political structures and councillors. Overall, the response to NCDs at the sub-national level is incoherent, lacks coordination with structures being disorganized, and is no longer receiving sufficient funding even for the HIV/AIDS response. Similarly, civil society and grassroots community-based organizations have become ineffective as they no longer receive the financial support that they used to get from NAHPA and external donor funding.

5.2.3 The challenges of primary care

Key government actors at various levels in Botswana demonstrated a high level of political commitment and leadership in putting together the Botswana Multisectoral Strategy for the Prevention and Control of NCD 2018-2023, placing it at the centre of the country's health system agenda. Study participants, however, considered the coordination and engagement of multi-sectoral systems capable of addressing cross-cutting issues related to NCD programmes to be weak. This was also supported by the participants from the private sector, civil society, and even government departments. Moreover, curative NCD programmes at the MoHW and preventive programmes at NAHPA had limited inter-departmental and intersectoral coordination, and everything appeared to be done haphazardly, with different actors working with their own agendas, and with no significant and sustainable results.

The study participants at the district-level considered that NCD service delivery was generally disconnected from community care and implemented as a vertical programme. The participants stated that no strong horizontal NCD programmes existed. In addition, the participants argued that most facilities were not ready to provide NCD services:

> *"I do not think our PHC units are ready to provide NCD services as they lack required inputs, including human resources."*

Several other participants from civil society suggested that lessons learned from HIV for primary care can serve as examples of good practice for integrated service delivery. This primary care model according to civil society organisation respondents can be adopted as a strategy for effective NCD service delivery. Participants described gaps in having a support mechanism and clear strategy for NCD-related training at the PHC level.

> *"There is no specific training for NCDs. There is a gap in knowledge and preparation to teach the community, especially for the NCD programme*."

The bottleneck for delivering NCD services at the primary level was described by participants to be caused by shortages of medical supplies, bureaucracy around procurement and distribution of medicines, and inadequate funding. One district-level respondent (D1 DH NGAM) stated:

> *"We have a limited number of PHC facilities with functional blood pressure apparatus, glucometers and other equipment, which impacts the implementation of NCD care."*

5.2.4 Contrasting the sub-national HIV response and NCD response: tensions and expectations

The district-level respondents noted that the country has well-developed structures for the HIV response, performed through decentralized healthcare services from national to sub-national level. Furthermore, there are also well-established HIV programmes such as task-shifting, counselling, community engagement, drugs and diagnostics procurement, and treatment adherence support for the management of HIV. All these HIV programmes could now be used to inform the development of other high-quality chronic care services for NCDs. However, the participants stressed that, in general, health service provision in the country remains poor, as little progress has been made in the response to NCDs despite their inclusion in the NDP 11 and in the Botswana Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023. The study participants at the sub-national level emphasized that the above-mentioned existing programmes and structures could be utilised in the response to NCDs, to jump-start the NCD response. Furthermore, the study participants emphasized that the District Multisectoral AIDS Committees (DMSAC), VMSACs and TACs could be repurposed

and used to respond to NCDs. However, these structures are still focused on the response to HIV/AIDS.

The sub-national level respondents stressed that their health promotion and NCD units are limited in terms of effecting a meaningful response to curb the NCD epidemic, in contrast to the response to HIV/AIDS, for a number of reasons. First, they stressed that the HIV response in Botswana was driven by strong political commitment and a functional and well established multi-sectoral approach. Second, the current structures as already indicated are only focused on the response to HIV and this is so because NCDs have not been budgeted for and there are no trained personnel at the sub-national level to enable effective NCD responses.

The MoHW NCD programme is headed by a junior medical officer at the MoHW headquarters, and there are no human resources specifically dedicated to fighting NCDs at both national and sub-national levels. Similarly, a small budget was allocated to the control of NCDs at the national level and not at the sub-national level. The budget allocated for NCDs is minimal, unlike for HIV/AIDS. The participants at the sub-national level also highlighted that HIV/AIDS received a lot of funding and donor support, unlike NCDs. The funding of HIV/AIDS responses in the country came from the Global Health Initiatives (GHI), Bill and Belinda Gates Foundation, and drug company Merck partnerships with African Comprehensive HIV/AIDS Partnerships (ACHAP), and Botswana Harvard partnerships, which signified commitment by the country to become the first country in Africa to provide free antiretroviral therapy (ART) and also become the first country to introduce Prevention of Mother to Child Transmission (PMTCT) programmes. The country's response to HIV/AIDS was well-recognised globally, and it became the international case study for effective disease control at scale. Therefore, the experience of HIV for which the donors gave huge funds created the expectation that they would fund NCD programmes in the same way. However, for various reasons the donors have not done so, which has contributed to a haphazard response lacking focus and vibrancy.

The officials at the sub-national level stressed that the over-dependency on donor funding and support from international agencies meant that NAHPA's response was confused and incoherent, haphazard, and lacking clear direction in the

implementation process. The respondents stressed that NAHPA was no longer engaging with them as they did in the response to HIV/AIDS, as decentralized health services delivery, particularly HIV/AIDS, received funding through them. Although the Botswana Multisectoral Strategy for the Prevention and Control of NCDs emphasized that the structures that were used in the response to HIV/AIDS could be revitalised and used as platforms for the NCD response, the sub-national respondents stated the following:

> *"We can do the same thing for NCDs and that's what I thought was going to happen, we are going to help these platforms, and the wellness committees at district level. I thought they would be the ones that were responsible for actually responding to NCDs but there's nothing like that."*

The sub-national-level respondents went further by stating that the NAPHA has not established any formal or informal connection with the districts in terms of the NCD response (but having said that, previously, there was also no direct link between NAHPA and sub-national level structures such as DMSAC and VMSAC responsible for coordinating the HIV/AIDS response).

The overall objective of a multi-sectoral approach would be to increase access to NCD prevention, care, and treatment programmes, and increase support to community organizations and the private sector, just as it was with the response to HIV/AIDS. For instance, when Botswana restructured NACA to become NAHPA in 2019, it was primarily established to ensure coordination and harmonization of the inputs from various government ministries, civil society organizations, and the private sector.

One of the sub-national respondents gave an example of the turnaround time for pap smears which she said is still long, leading to late diagnosis of cervical cancer which in turn leads to a reluctance among women to screen for cervical cancer. According to sub-national-level respondents, most laboratories in the country do not perform HBA1c long-term blood sugar tests to monitor the control of diabetes among those who are affected, and stressed that the lower-level facilities are sometimes unable to screen for diabetes because of a shortage of glucose test strips. Furthermore, officials at the sub-national level indicated that compounding these challenges is the general shortage of medications in the fight against NCDs as patients are frequently switched to different regimes based on the availability of

medication, which affects monitoring and control of their illnesses, leading to undesirable complications and sometimes death.

There was some consistency between the NAHPA respondents; three officials from the NAHPA stated that the response to NCDs and risk factors at the district level was still a work in progress, and that currently, they have sub-contracted some community-based organizations and NGOs to carry out some NCD-related activities at the district level supported by funds from NAHPA.

Although there is an intent to respond to NCDs, this has not translated into action. Currently the response remains predominantly focused on HIV/AIDS. Coupled with this government (in)action has been rising job insecurity fears among the MoHW senior management team, arising because many had already been dismissed from work during COVID-19. Furthermore, the changes and redeployments among the senior management team and Minister at the MoHW, and overall government machinery, have had a negative impact on the continuity of health service delivery and the successful implementation of the National Strategic Framework on NCDs 2018-2023 (NSF 2018-2023). Lack of preventive infrastructure, restrictions on access to medicine, poor coordination, and stock-outs have curtailed the effective response to NCDs in the country, both at the national and sub-national levels. Lastly, restrictions on PHC to mobilize communities at the sub-national level with effective operational structures emulating those used in the response to HIV/AIDS remains just a dream. Poor coordination and stakeholder engagement, leading to private sector and civil society alienation, have hampered the response to NCDs, and the latter's response is still also fixated on the response to HIV/AIDS.

Senior officials from NAHPA (A1 NAHPA2q1) explained what the existing structures are currently (at the time of the study), with one official describing how they relate to each other:

> *"There is a unit within the Ministry of Health and Wellness called the NCDs unit. This unit works closely with NAHPA; although NAPHA is a stand-alone department, there is a coordinator within the Ministry that is not at the Deputy Permanent Secretary (DPS), but he also acts nationally. He works with NAHPA to link all these information and the data from the DHMT goes to this unit. This unit now reports to the deputy PS Health Service Management. And from there I guess that's where then NAHPA, gets the*

data maybe to look at analysing the data and see what can be done going forward."

5.3 NCD Prevention through the Reconfigured National AIDS and Health Promotion Agency (NAHPA): the Politics and Challenges of Replicating HIV Structures for NCD Prevention

In 2019, the National AIDS Coordinating Committee (NACA) was reconfigured to become the National AIDS and Health Promotion Agency (NAHPA) and was charged with responsibility for NCD preventive activities. This decision was taken to help implement the Botswana Multisectoral Strategy for the Prevention and Control of NCDs (also referred to as the National Strategic Framework 2018-2023). As this section shows, however, implementation processes have been impeded by poor coordination between sectors, and siloed approaches. Consequently the response remains mostly focused on HIV/AIDS at both national and sub-national levels.

Although a national strategy has been in place since 2018 in response to rising NCD burdens, participants referred to leadership gaps in contextualizing and implementing the strategy at PHC level. The findings show that limited attention has been given to NCD responses at the national and sub-national levels, stalling progress at PHC level with implementation of all NCD programmes. The reasons for this are poor leadership and poorly coordinated efforts by NAHPA to ensure a multi-sectoral approach at national and sub-national levels. Issues of political commitment, policy and governance, health system readiness, provider knowledge, weak NCD structures at the sub-national level, multi-sectoral fatigue, lack of skills and training, and financial constraints, have all been identified as impediments in the response to NCDs, as discussed below.

5.3.1 Reconfiguring NACA to NAHPA: bureaucratic politics and controversies

The study participants from NAHPA (A1 NAHPA) described how NAHPA was established and illustrated that it was formed as a strategic department to coordinate the national response through a sustained multi-sectoral partnership to prevent new HIV infections, and reduce the burden of NCDs as well as HIV/AIDS. The respondents stated that the multi-sectoral approach to NCD responses extended to the sub-national structures and government departments such as

District AIDS Coordinators (DACs) and DHMTs through an extension of formal and informal networks.

However, the DHMT respondents stated that they do not work directly with NAHPA, but do, however, interact with them at the sub-national level through decentralised government structures. The DHMT participants emphasized that the treatment mandate for NCDs at the sub-national level is their sole responsibility whilst prevention is the responsibility of NAHPA/DAC. A similar division of responsibilities has been made at national level, where the MoHW is responsible for NCD curative aspects and NAHPA for prevention and promotion aspects.

The district sub-national level respondents, (D1 DH NGAM, D1 DH Kgatle and D1 Cen DH) also stressed that at the district level, DHMT is responsible for responding to NCDs and risk factors, and collects data sent to the Ministry of Health NCD unit every six months. Two of the three officials from the MoHW stated the following:

> *"So, we, as a ministry, our role is to make sure that we monitor anything in relation to Non-Communicable Disease, the NCDs, and you know that is lifestyle."*

> *"NAPHA is mainly charged with the promotion and education aspect of NCDs. However, when it comes to clinical management [...] it's still managed at the Ministry of Health and Wellness level, which is the NCD unit."*

The dichotomy was also noted by a NAHPA official (A1 NAHPA2q1):

> *"Although NAHPA was set up to deal with the national response to NCDs and risk factors, the treatment aspects of NCDs are still led by the Ministry of Health and Wellness, while the prevention aspect is the mandate of NAHPA."*

The reconfiguration of NAHPA from NACA has not been without controversy, leading to power tussles between the MoHW and NAHPA, as the latter served as the secretariat of the Council, which was previously the mandate of the MoHW.

The study findings show that NACA was established with an ambitious mandate to coordinate and mobilize responses in HIV and AIDS from other sectors, including civil society and the private sector in the country. The findings show that the

establishment of NACA in the country was carried out in accordance with the UNGASS 2001 which recommended two different models of a NACA: it could be a stand-alone institution independent of any government ministry, or a unit within a given ministry (usually the Ministry of Health). The study findings also indicate that the NACA model adopted in any one country was highly context-dependent and dependent on the stage of the epidemic, breadth of response, number of stakeholders, and National AIDS Coordinating Authorities. Stand-alone NACAs tend to comprise two bodies that together are expected to coordinate and facilitate the national response: a governance body or Board of Commissioners, most often referred to as the National AIDS Commission/Council (NAC), and the operational body known as the National AIDS Secretariat (NASs). In Botswana, this stand-alone model was adopted, and the NACA was moved from the MoHW.

While NAHPA was mandated to carry out national-level coordination on NCDs and risk factors, the study participants from NAHPA indicated that they faced numerous challenges in the response to NCDs, as they have not yet established operational structures responsible for effective national responses, nor started sub-national level implementation processes. The participants from NAHPA stated that when they were transitioning, some personnel from the Ministry of Health NCD unit were transferred to NAHPA to set up the NAHPA NCD response section. The participants indicated that this was done so that lessons learned in the prevention of HIV and AIDS epidemics could be applied in the fight against NCDs nationwide. According to one of the NAHPA officials (A1 NAHPA2q1), the transfer from the MoHW was also motivated by the desire to awaken the same energy levels that were used in the HIV/AIDS prevention response and so to propel NCD prevention by adopting HIV/AIDS methods. These HIV prevention and self-management approaches and methods recognise that there is no effective cure for HIV, it has become a long-term chronic or manageable condition, so that prevention is much cheaper than treatment for long-term conditions such as HIV and NCDs.

The position of NAHPA, then NACA, right from the beginning, has been controversial, as one of the sub-national respondents noted:

> *"The issue about NAPHA being under the Ministry of Health and Wellness was on the table when I was at NAPHA, NACA then, when I was there, there was that issue where NACA was to be considered a department under*

Ministry of Health and Wellness. But as you know, government then rescinded on that."

There was much mistrust and disgruntlement when the government decided to move the NACA from the MoHW to be a stand-alone institution (becoming NAPHA). However, it is important to note that when NACA was repositioned from the MoHW as part of the agreement that was reached by the African Union and UNGASS 2001 to have it fall under the highest political office, Office of the President, the intention was to provide NACA with greater authority, mark their independence from other arms of government so they can coordinate other sectors, and demonstrate political commitment to the fight against HIV.

In line with the Botswana Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023, officials from NAHPA (A1 NAHPA2q1) stressed that there was an intention to replicate the same structures and models for NCDs that were used in the HIV/AIDS response. They (A1 NAHPA2q1) said they felt there was an urgent need to leverage the response to HIV/AIDS that was multi-sectoral and had effective structures at both the national and sub-national levels, such as DMSACs, VMACs, and TACs that worked with different stakeholders, civil society, and donor agencies. These sentiments were also shared by the sub-national-level respondents and all civil society organizations interviewed.

Consequently, the NACA was reconfigured to NAHPA to focus on three key pillars: NCD prevention and health promotion, monitoring and surveillance, and governance, partnerships, and multi-sectoral coordination. According to officials from NAHPA (A1 NAHPA2q1) these responsibilities were to build on the existing structures already constructed, evaluated, and improved in response to the HIV/AIDS epidemic over the past years in the country. The respondents regarded the government's decision to transition the prevention and control of NCDs to NAHPA as a positive move for NAPHA.

"NACA now NAPHA was even strengthened by taking care of the NCDs."

NAHPA respondents were clear that are still focused on the response to HIV, despite the attempt by the government to develop a multi-sectoral strategy to integrate NCDs into health service delivery, and that they have the full mandate to operationalize its implementation at the national level. NAHPA respondents (A1 NAHPA2q1) explained that this is so because of an insufficient budget and lack of

trained human personnel to enable effective NCD responses. The officials stressed that compounding this is the lack of donor support for NCDs, who still give priority to the HIV/AIDS response. The respondents also stressed that multilateral agencies remain in favour of HIV/AIDS compared to NCDs. This was also confirmed by respondents from the civil society groups, who stressed that they received large funding to respond to HIV/AIDS and not to NCDs, and also indicated that the donors also set the agenda on the key priority areas to be implemented.

5.3.2 Sub-national coordination and Implementation challenges

When discussing sub-national coordination and implementation challenges, it is important to provide a contextual perspective on the direction of the Botswana National HIV/AIDS response. As already discussed, the National AIDS Coordinating Agency (NACA), before it was transformed into NAHPA, had responsibilities to align multi-sectorial efforts towards achieving national and international targets, and it supported civil society organizations and private funding mechanisms. Development partners and unilateral organizations also worked closely with NACA and the MoHW to achieve harmonization and shared goals. NACA reported quarterly to the National AIDS Council (NAC), chaired by former president Festus Mogae, and assisted by the Vice President.

The respondents from NAHPA stressed that a large part of their work is still on HIV programmes, on community mobilization and engagement for prevention:

> *"We are really the division that is heavily leveraged on community structures to ensure that HIV/AIDS education issues, especially the social norms, are heavily addressed by the community leaders, the owner of the tradition"* (A1 NAHPA).

However, the way in which they reach community structures is complex. Respondents from the sub-national level, senior officials from MoHW, and the two officials from the Ministry of Local Government and Rural Development all indicated that NAHPA does not work directly with the districts but works with the districts through the Ministry of Local Government and Rural Development, which used to be responsible for PHC before it was reformed in 2010. The revitalisation of PHC split PHC responsibilities into two: curative care undertaken by DHMTs and HIV/AIDS prevention undertaken by District AIDS Coordinators (DAC) at the district

level. The DHMT works with the DAC, and reports directly to the MoHW and not the Ministry of Local Government, and is not a department under the district council as previously. The sub-national respondent stated:

> *"These programmes are expected to reach different communities and are channelled through the office of the Permanent Secretary (PS), Local Government and Rural Development. Then, an officer at the Ministry of Local Government at the PS office will write to us, and this is how we connect with the District AIDS Coordinators, and then NAHPA. NAHPA funds our programmes and is responsible for HIV coordination at national level.*"

The sub-national-level respondents were clear in stating that the NAPHA does not have direct links or connections with the sub-national-level structures in the NCD response. However, it is important to note that the overall development objective of the multi-sectoral approach is to increase access to NCD prevention, care, and treatment programs, and increase support to community organizations and the private sector, just as it was with HIV/AIDS. One would expect that NAHPA has to strengthen its workforce and structures to have formal or informal links with district-level structures for NCDs responses. NACA was also mandated to monitor decentralization of HIV/AIDS policies and their implementation at the district level and ensure integration of HIV/AIDS policies into district development plans coordinated by the Ministry of Local Government and Rural Development, stating that the same model could be emulated in response to NCDs.

There was some consistency from the respondents from NAHPA (A1 NAHPA2q1), highlighting that not much has been done to respond to NCDs at the sub-national level. They stressed that they have sub-contracted some Community Service Organisations (CSOs) to carry out some NCD-related activities, as discussed earlier in this chapter, and this includes amongst others educational campaigns on the harmful use of alcohol and substance abuse. According to NAPHA respondents (A1 NAHPA2q1) the Alcohol Division in the MoHW receives funding from NAHPA from the alcohol levy. However, they stressed that the funding is limited to enable them to carry out functions and programmes widely.

5.4 Ministry of Local Government and Rural Development: Unclear Roles and Relationships for NCD Response

This section explores the role and function of the Ministry of Local Government and Rural Development for NCD responses in the country. It first starts by providing an illustration of the powers and functions bestowed on local government through national statutes. This section also discusses the local level structures used in the response to HIV/AIDS, such as District Multisectoral AIDS Committees (DMSACs) and Village Multisectoral AIDS Committees (VMSACs). It also asks why these structures have failed to effectively respond to NCDs, as set out in theory in the Botswana Multisectoral Strategy for the Prevention and Control of NCDs.

In Botswana, the Ministry of Local Government and Rural Development oversees 16 local authorities and semi-autonomous local authorities categorized into City, Town and District Councils, inclusive of tribal administration. Local government power can be classified into legislative and executive categories. Legislative power refers to the law-making role. Executive power refers to the power to implement and enforce local laws (by law), as well as to implement policies. Public health is also the primary responsibility of local government.

According to the respondents at the sub-national level, PHC used to fall under the districts and local authorities, and this was administered through health posts which serve remote and rural areas, clinics, primary hospitals, and district hospitals. The study findings show that PHC services have been integrated within the overall hospital and healthcare services and are provided in the respective outpatient departments of hospitals. The central government provides referral services at Princess Marina in Gaborone and at Nyangabgwe Hospital in Francistown. Hospital care, medications, and laboratory tests are free for all citizens in public-sector facilities. The respondents at the sub-national level stressed that each district has a district health team led by a public health specialist who is responsible for the administration and supervision of a number of public health diseases such as tuberculosis and HIV. In addition, faith-based hospitals and mining companies also provide a parallel system of PHC through a complementary network of clinics and hospitals in the country.

At the sub-national level, the Ministry of Local Government and Rural Development and DHMTs are bonded by the Government of Botswana District Planning

Handbook 2002, and it is at this level where integration of NCD-related activities are presented into district development plans and annual work plans. The District Planning Handbook, 2002 presents the structures at the community level (district and village levels). The institutional set up of planning in Botswana can be divided into three levels: District Level, Community Level, and Central Government level. The institutions at the District level are the District Administration (established by 1965 Act of Parliament), District and Town Councils (established by 1965 Act of Parliament, Land Boards (established by 1968/1970 Act of Parliament) and Tribal Administration (established by 1965 Act of Parliament).

The District Commissioner (DC), who is responsible to the Ministry of Local Government and is a senior representative of Central Government in the District, heads the District Administration. He/she is the chairperson of the District Development Committee (DDC), which is in charge of preparing the District Development Plans, thus the coordination function of the DDC is very critical. The DDCs have the power and the discretion to allocate resources within their area of jurisdiction. They exist however side by side with locally based officials of various government departments. These include such committees as Education, Health, Works, Trade and Licensing, Physical Planning, etc. At DDC the DHMT is bonded with the Ministry of Local Government and Rural Development. The DHMT is also bonded with the Ministry of Local Government and Rural Development through other structures such as DMSAC and VMSAC and TAC.

The institutions at the community level are, a) the traditional institutions, comprising of chieftaincy and b) sub-chiefs, village headmen and ward heads and they are serve as the link between communities and government structures (authorities). At the community level there are the Village Development Committees (VDC) and their functions as per the Government of Botswana District Planning Handbook 2002, are amongst other things to identify and discuss local needs, and help villagers to prioritize their local needs.

The city/town and districts councils previously used to be responsible for the delivery of PHC services through health posts, which serve remote and rural areas, clinics, primary hospitals, and district hospitals. Integration of NCDs into HIV/PHC structures is the responsibility of the District AIDS Committee (DAC), who is mandated to coordinate district-level HIV/AIDS/NCD activities, mostly in relation to

preventive activities. Curative aspects of NCDs and their integration into HIV/PHC is the responsibility of the DHMT. DMSAC meets on a quarterly basis to discuss HIV/AIDS programming updates and district challenges. However, the study findings indicate that DMSACs main mandate is still within HIV/AIDS and not NCDs. DAC's work is still predominantly focused on the response to HIV/AIDS and not on NCDs. Two officials from the Ministry of Local Government (AI MLGL & RD) stated:

> *"DMSACs are chaired by the District Commissioner and the secretariat is DAC. There is no budget line for NCDs at the District Councils. DMSACs work only on HIV/AIDS and not NCDs."*

> *"We also do no longer receive a lot of funding for HIV/AIDS, especially after COVID-19."*

The findings indicate that there is slow implementation of the strategy and a lack of incentives and resources for the Ministry of Local Government and Rural Development to effectively implement the NCD strategy, as they have not received clear guidance from NAHPA. Officials from NAHPA (A1 NAHPA2q1) stressed that they also do not receive adequate funding for HIV/AIDS from NAHPA, as used to be the case. One respondent from the Ministry of Local Government (A1 MLGL& RD) stated the following:

> *"We no longer receive funding from NAHPA like we used. We used to get a lot of funding from NAHPA for HIV/AIDS and we do not get anything for NCDs either."*

For these respondents, the limited funding they receive from NAHPA has greatly hindered lower-level structures, such as DMSACs and VMSACs, in responding effectively. Respondents from the Ministry of Local Government (A1 MLGL&RD) also stressed that they have not set up an NCD unit according to the requirements of the NCD strategy. Furthermore, Ministry of Local Government officials (A1 MLGL&RD) indicated that they have been looking at ways to revitalize PHC, to enable them to be better positioned to start proper integrated health services, including NCDs.

The sub-national level respondents indicated that for an effective NCD response at this level, the same district and village structures of the DMSAC and VMSAC which

were used in the HIV/AIDS response could be adopted or replicated in the response to NCDs. The respondents stated that the DMSAC, in collaboration with District Development Committees (DDCs), are pivotal organs at the district level for leadership and coordination of all HIV/AIDS-related activities, and that in the response to HIV/AIDS, these structures were well-coordinated and worked effectively. According to the respondents, each district had district HIV/AIDS Coordinators solely responsible for coordinating HIV/AIDS activities at various levels of jurisdiction. However, according to the sub-national level respondents, these structures continue to work in response to HIV/AIDS activities but *not* on NCDs.

The respondents stated that despite being the leading cause of morbidity and mortality in the country, there is no line budget to address NCDs at the sub-national level and NCDs are also not included in the budget like other communicable diseases are and no one in authority has ensured that NCDs are given priority. The respondents stressed that as result, this has led to poorly resourced primary care and stressed that to improve the efficiency and utilization of available resources, there is a need for a balance between funds earmarked for care in tertiary care institutions and basic services provided at the primary care level.

5.5 Perspectives on Leadership and Political Commitment Across Guiding Institutions

This section presents the views and perceptions of the participants regarding the level of political commitment and leadership in the country's response to NCDs and risk factors. The participants were drawn from government institutions, civil society organizations, the private sector, and sub-national level structures. While the study participants agreed in consensus that the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs was a step in the right direction, some civil society and private sector study participants held the view that the development of the NCD strategy in the country was not inclusive, as some of them were not invited to form part of the technical working groups and steering committees. For instance, respondents from the private sector, in this case the Botswana Medical AID Society (health insurance sector), (PI BOMA), stated:

"*We were not selected to participate in the development of the NCDs Strategy in Botswana. We knew about its development but no one from the Ministry of Health and Wellness cared to invite us.*"

For these respondents, the development of the country's NCD strategy was not inclusive, suggesting that leadership was selective and chose to work with their preferred institutions and individuals, while excluding other key actors. The participants also stressed that political commitment was lacking for actual implementation of the strategy, and that poor leadership was visible in the implementation of NCDs compared to HIV/AIDS. This perceived lack of political commitment and poor leadership was consistent with the perspective of a government MoHW respondent (2 MOHAL MoHW), who despite working for the MoHW, suggested that:

"There is no longer the political support and commitment regarding the harmful use of alcohol. Ever since the former President stepped down, the regular meetings of the Alcohol Committee at the Office of the President also stopped."

"The Inter-Ministerial Committee on Alcohol also no longer meets at the Ministry of Health and Wellness."

For these respondents, the perceived disorganization and limited attention given to NCD responses in the country due to poor leadership and lack of political commitment may have contributed significantly to the clear lack of direction and incoherence of the NCD response, leading to a siloed approach at the national level. Ministry of Local Government respondents (A1 MLGL&RD) stressed that the structures at the sub-national level are also fatigued (meaning they are not properly resourced, both financial and there is also lack of trained human resources to tackle the response to NCDs, they are also faced with logistical problems and have frequent stockouts) in their response to HIV/AIDS as they no longer receive sufficient funding for HIV/AIDS. According to one of the officials from the Ministry of Local Government (A1 MLGL&RD):

"Even the structures at the district level are not adequately resourced to respond to HIV/AIDS. Even volunteerism is no longer very active. We no longer receive enough funds from NAHPA to channel them to district level structures."

The above comments reflect the fact that funding for HIV/AIDS has been declining since about 2009. Reports show that since 2013, developmental partners funding decreased, and that prior to that between, 2009 and 2012, PEPFAR funding alone also decreased by over 30 million, (108). In 2013, the Gates Foundation also withdrew donor support. Due to Botswana's classification as an upper-middle-income country, the Centers for Disease Control (CDC) and African Comprehensive HIV/AIDS Partnerships (ACHAP) also completely withdrew funding support. The Merck Foundation also cut their 10 year drug donation by 90%, (108).

Data from both the interviews and secondary sources therefore suggest that Botswana now faces even greater challenges in sustaining its success in fighting a disease double burden without significant donor support. Compounding significant human resource constraints, as well as complex and often contradictory socio-cultural realities, pose serious barriers to the successful implementation of NCD strategies. The country's impressive HIV response was driven by strong and sustained political will, and enabled through generous development partner funding, but these important factors contributing to success have now, it seems, diminished, as the country is failing to replicate the success story of its fight against HIV to respond to NCDs.

Interview data indicate there is minimal support for an NCD response in practice from the national level to sub-national level. For instance, respondents at the Ministry of Local Government and Rural Development (A1 MLGL&RD) stressed that they no longer receive enough funding for HIV/AIDS from NAHPA. They also stated that they do not receiving anything for the NCD response. For these respondents, the leadership seems to be less interested and detached, and there is a clear lack of vibrancy witnessed in response to NCDs. Furthermore, at the sub-national level, there is a level of disconnect and confusion among the various relevant committees about their specific roles and functions with respect to NCDs (District Development Committees (DDC); District Multisectoral AIDS Committees (DMSACS); Village Multisectoral Committees (VMSACS); and Technical AIDS Committees (TACS)). For instance (D1 DH NGAM) stressed the following:

> *"I am responsible for convening DMSAC meetings. So we are the Secretariat and not DAC."*

These respondents are responsible for DMSAC, while the DMSAC Secretariat is responsible for DAC. There are also many structural issues at this level, such as the DHMT sitting as the TAC Secretariat.

The lack of political support and effective leadership at the national level has had negative effects for political responses at the sub-national level, and at sub-national decentralized health system structures. The district-level respondent (D1 DH NGAM) stressed that political leadership to drive the response to NCDs at the sub-national level is lacking, unlike the case of HIV/AIDS. The district-level respondent (D1 DH NGAM) stressed that the HIV/AIDS response received a lot of national and local political support, which was vibrant, visible, and effective. The study findings also show that poor coordination and lack of stakeholder engagement, with civil society and private sector actors feeling alienated, have also hampered the response to NCDs at both national and sub-national levels. Lastly, there are a lack of resources, capacity weaknesses among the actors involved, and lack of coordination and collaboration by the guiding institutions in response to NCDs.

5.6 Summary and Conclusion

This chapter has discussed the government actors (guiding institutions) and their networks involved in shaping the dimensions of NCD policy in Botswana, their interconnections, and how they were involved in the NCD policymaking or policy un-making. Certain bureaucratic power struggles, leadership issues, and capacity weaknesses which hindered implementation have been discussed. It has also discussed the relationships between the actors at national and sub-national levels, and illustrated how they work together (or not) in relation to NCD policymaking in Botswana. I have described the division of responsibilities, the coordination and connections or disconnections between the actors. Table 3 summarises the discrepancies between the actors' mandated roles and responsibilities and the realities as revealed through the interviews. The civil society, private sector, and development partners are discussed briefly for the purpose of understanding their relationships and interactions with the government guiding institutions but are discussed in more detail in Chapter 6.

Table 3: Actors Involved in the response to NCDs and risk factors and their mandated and actual roles

Organization	Roles in theory: official mandates, responsibilities and tasks	Roles in practice (key points)	Sources: Interviews & policy/admin documents
Ministry of Health and Wellness (MoHW)	The Ministry of Health and Wellness mandates and responsibilities are: • **Health service delivery**: Within the public sector, the MoHW is mandated with the responsibility for the provision of health services and oversight. Key to note that health services delivery in the country is pluralistic. There are public, private for profit, profit, private non-profit and traditional medicine practices. The MoHW is responsible for national health including policies, goals and strategies for health development and delivery. • Formulation of policies, regulations, norms, standards and guidelines for health services. • MoHW provides PHC services through District Health Management Teams (DHMTs). DHMTs are responsible for running a network of health facilities, hospitals, clinics, health posts and mobile stops as well as community-based preventive and promotion services. • Coordination of national policy response and planning. Implementation of health sector interventions, surveillance, awareness and advocacy. • Promotion of patient care services and organizational excellence. • Information management and dissemination, monitoring and evaluation, technical support coordination and resource mobilization.	• The Ministry of Health and Wellness gets data on NCDs and other diseases from DHMTs. • Limited collaborative efforts with NAHPA. • Creation of NACA (now NAHPA) brought structural tensions with the MoHW. When NACA was established, it was originally set up as a department under the MoHW but later due to the recommendations of UNGASS and AU it was repositioned to Office of the President (OP) to ensure effective political support. The MoHW even served as the secretariat of the National AIDS Council (NAC – Now National AIDS and Health Promotion Council -NAHP). This role and mandate has since been taken by the NAHPA who now serve as the secretariat of NAHP. • High staff turnover and redeployment of senior management staff at the MoHW affected continuity and stability in health service delivery in the country. The redeployment has caused anxiety amongst senior management about losing their jobs and or being redeployed by senior authorities in government. • Structural problems due to NAHPA being responsible for preventive aspects of NCD policy and the MoHW being responsible for curative care. This division was made by the government when the Botswana Multisectoral Strategy for Prevention and Control of NCDs was developed. • The restructuring and establishment of the National AIDS Coordinating Agency (NACA) was	**Interviews:** Three Senior officials, MoHW. Interviewed as a group. (A1 MoHW3). Permanent Secretary MoHW (A1 MoHW1). **Documents:** • MoHW website. (https://www.moh.gov.bw/) • Botswana Multisectoral Strategy for the Prevention and Control of NCDs. • Botswana National Policy on HIV/AIDS 2012. • Botswana Midterm Review 2020 • BWA Narrative Report 2014 • National AIDS Coordinating Authorities: A synthesis of lessons

		done in 1999, when the government decided to declare HIV/AIDS a national emergency. Initially it was established at the MoHW and later NACA was relocated to the Ministry of State President. • There are numerous challenges facing the country's response to NCDs.	learned & taking learning forward, 2005. • Botswana National Development Plan 2011.
MoHW Alcohol Division	• The MoHW Alcohol Division is responsible for problem identification and issue recognition in the area of alcohol control. • The Alcohol Policy encompasses many relevant actors at different levels, with a designated coordination mechanism at sub-national level. • It is the custodian of Alcohol Policy and serves as the secretariat for the Interministerial Committee on Alcohol in Botswana, chaired by the Permanent Secretary MoHW. • As the secretariat of the Alcohol Policy, it ensures that meetings are held regularly and thereafter the Interministerial Committee reports directly to the Office of the President. • It works closely with the Ministry of Finance on the alcohol levy. • It also works closely with Ministry of Transport, MVA and the Botswana Police Service. • It does not work with the alcohol industry.	• Staff shortages mean they lack capacity to execute their mandate. • The Division is also constrained by the budget and therefore is not able to effectively monitor compliance with the policy. • It does not have the authority and control on the alcohol levy and how the money collected through the levy is utilized. • As the secretariat of the alcohol industry, they no longer hold regular meetings as was the case in the past during the period of the previous President, who was a strong advocate on the harmful use of alcohol. • The Interministerial Committee has also become moribund, affecting the performance of this Division, hence their suggestion that perhaps this Division should be a stand-alone institution just like NAHPA with its own budget and personnel. • Ineffective leadership and lack of political support and continuity.	**Interviews:** Officials (2 MOHAL MoHW) at the Alcohol Division. **Documents:** • Desk review of the Botswana Alcohol Policy 2017. • Botswana Alcohol Policy. • Botswana Alcohol levy regulations.
Assistant Minister, MoHW	• Setting standards for the delivery of healthcare in the country. • Providing strategic direction for health delivery services. • Monitoring and evaluating health service delivery.	• Is an Assistant Minister of Health who is junior to the Minister and is only responsible for providing political oversight while most of the work is done by the Permanent Secretary and the consultant.	**Interviews:** Assistant Minister, MoHW (A1 MoHW4).

	• Providing coherent system-level leadership that aligns priorities and focus across the health system and across government. • Overseeing laws governing the country's healthcare system. • Strategic direction for health delivery services. • Given the primary mandate to focus on the response to NCDs and palliative healthcare. • Committee member of IMCTCP and NMRFI.		**Documents:** • Botswana Multisectoral Strategy on the Prevention and Control of NCDs. • Botswana National Policy on HIV/AIDS 2012. • National Development Plan 11 • Botswana Health Policy • Alcohol Policy • Alcohol levy • WHO website • Ministry of Health and Wellness website
NAHPA	• Responsible for preventive aspects of NCDs and to ensure the successful implementation of the Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023. • Specifically: awareness and advocacy, services for prevention, educational services, support, information management and dissemination, coordination and resource mobilization.	• NAHPA was originally NACA. At the time of its formation it was housed at the MoHW as a department and in 1999 this was changed, with the appointment of the National HIV/AIDS Council and NACA was relocated to the Ministry of State President. • In 2019 the Botswana National Strategy for the Prevention and Control of NCDs was launched by His Excellency, President Mokgweetsi Masisi. NACA was renamed NAHPA to incorporate NCDs into health services delivery. • The importance of the link between national and district level in execution of the mandate of the national response to NCDs and risk factors remains paramount to the national response. The current structure has DMSACs and VMSACs and district and local level actors, but these	**Interviews:** Group Interview with the three Senior officials from NAHPA (A1 NAHPA2q1). **Documents:** • Botswana Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023. • Botswana National Policy on HIV/AIDS 2012.

		structures have no direct link with NAHPA and Health Promotion. • Coordinating role and engagement with stakeholders, civil society and private sector. • The NCD unit within NAHPA was established with two staff members transferred from the MoHW. • Financial constraints and lack of trained human resources are hampering implementation at national and sub-national levels through a network of services.	• Print media and newspaper articles. • Botswana Health Policy.
Ministry of Local Governme nt and Rural Developme nt (MLG)	• The Ministry of Local Government provides some public health services including providing environmental health services. • Contribution to population-wide awareness and sensitization, engaging and mobilizing communities to ensure participation in awareness, planning and response implementation. • Integration of NCD-related activities into district development plans and annual work plans, coordinating district level NCD activities and information gathering. Awareness and advocacy, prevention services, and support. Information management and dissemination. coordination and resource mobilization. • The districts and local authorities previously used to be responsible for the delivery of PHC services through health posts, which serve remote and rural areas, clinics, primary hospitals, and district hospitals. • Each district has a district health team led by a public health specialist who is responsible for the administration and supervision of several public health diseases such as tuberculosis and HIV. Each district has an average of 3 or	• The country has a two-tier government structure with the health system being decentralized through administrative decentralization. as defined by Rondinelli (81). • The health system is decentralized with split roles between DHMT and District Councils/Town and City Councils. Councils are responsible for environmental health services. • Of great importance to note is that PHC is cross-cutting, covering tertiary and primary care. • There are variations in the country in the provision of NCD services at sub-national levels; in some areas there are no NCD services. There are few clinics that are designed specifically to provide NCD health services; most of them offer integrated services, although highly ill-equipped with lack of resources and incentives. • There is a lot of overlap and confusion in the roles of the District Councils and the DHMT. For instance, HIV/AIDS response at the district level falls under District Administration led by the District Commissioner who also chairs DMSAC. At times DHMT thinks the roles they perform are theirs when they are a clear mandate of DAC.	**Interviews:** Group Interview: two senior officials from MLG (A1 MLGL & RD). **Documents:** • Botswana Multisectoral Strategy for the Prevention and Control of NCDs. • Botswana National Policy on HIV/AIDS 2012. • Botswana Planning Handbook 2002. • Botswana Health Policy.

	more posts for health promotion officers depending on the size of the district. • HIV/AIDS coordination at the district level is multi-sectoral and each district has two committees: the District Multisectoral AIDS Committee (DMSAC) and Village Multisectoral AIDS Committee (VMSAC). • Each district has its own DMSAC which is funded by the National AIDS Coordinating Agency (NACA) through the MLG. • Since the revitalization of PHC, PHC services are now provided by the DHMT which reports directly to the headquarters MoHW.	• DMSACs/VMSACs and TAC have no direct link with NAHPA. They deal formally with NAHPA through the Ministry of Local Government and Rural Development. There is therefore disconnect between sub-national level structures with NAHPA. • No NCD unit set up at sub-national level structures. Both at DHMT and DACs. Response still focused largely on HIV/AIDS response. • Confusion on their role and responsibilities in responding to NCDs. • No budget for NCDs but also now receiving limited funding for HIV/AIDS from NAHPA.	
Presidential Affairs, Government and Public Administration (OP)	• Providing high level support and leadership to facilitate policy and institutional arrangements that promote multi-sectoral participation. • Facilitating integration of NCD-related activities into each sector strategic plan. • Facilitating the process of legal and legislative reforms relevant to NCDs, including for alcohol, tobacco. • Enforcing legislation relating to alcohol use, tobacco use.	• Chairs the National AIDS and Health Promotion Council (NAHP). • Gets consolidated reports from NAHPA on the country's response to NCDs and HIV/AIDS as the national coordinating institution and from the MOHW • The political will to respond is there but this is not supported by the financial support and in-sufficient budget, trained personnel and infrastructure both at national and sub-national level to do so.	**Interviews:** Senior Official at OP. (OP 1). Made numerous attempts to interview the Chair of National AIDS and Health Promotion Council (NAHPC) committee. Unfortunately, was not able to. **Documents:** • Botswana Multisectoral Strategy for the Prevention and Control of NCDS. • National Development Plan 2011.

			• State of the Nation Address, 2019. • Botswana National Policy on HIV/AIDS • Botswana Midterm review. • UNGASS 2011 articles. • Botswana Health Policy 2010. • Alcohol Policy 2011.
Civil Society Umbrella / Apex body	• The apex body: all NGOs are expected to be affiliated to it. • Direct link with the government through meetings and serves in high consultative meetings with the government structures. • Various civil society organizations participate in implementation of national efforts, in particular individual and community-based interventions including hard to reach and vulnerable areas and groups.	• Serves more as the voice of all the NGOs and has direct links with the government. • Whenever, there is a programme or project to be undertaken, the apex body links the NGO or CBO whose mandate falls within what has to be undertaken in the project.	**Interviews:** Umbrella body, donor funded & community driven. Official from LEGABIBO: (C1 LGB). Two Senior Officials from BOCONGO, (C1 BCG1) (C1 BCG2) **Documents:** • Website portals • Digital platforms sites.
NGOs: Donor funded & home grown	• Receive funding to carry out HIV/AIDS project delivery. • Most of their programmes and projects are donor driven. • The donors set the agenda and determine how their funds are to be used, when and how, with strict monitoring.	• Siloed approach in the response to NCDs. • Does not get the support from NAHPA • Some are left out in the consultative process by NAHPA. • No national tools and guidelines for high population risk groups. • Over dependence on donors whose priority and focus remains on HIV/AIDS.	**Interviews:** Group Interview: Three Senior officials from BOCAIP, (C1 BCP).

	• Some participated in the development of the Botswana Multisectoral Strategic Framework for the Prevention and Control of NCDs. • Some work with high-risk groups, but there are no national guidelines which they can use to assist this community. As a result NGOs have decided to develop their own tools and guidelines. • Limited funding and poorly resourced. • To date, limited work in NCDs. Only now some of them have started to carry out screening for breast cancer, diabetes and high blood pressure, assisted by the private sector (mining). No longevity in carrying out all these.	• Little action from them in the response to NCDs. • Donors set the agenda on how their funds ought to be used. • Donor support for HIV/AIDS has also dwindled. • Limited funding on NCDs from homegrown sources. Only limited funding from NAHPA to some NGOs and CBOs which is equally not sufficient.	Group Interview: Two Senior officials from BONELA, (C1 BON). Group Interview: Two Senior officials BOSASNET, (C1 BOSAS). Official from Cancer Association: (C1 CA A). Official from Journey of Hope, (C1 Jo Hop). **Documents** • Website portals from all the interviewed donor agencies and developmental partners.
District Health Management Teams (DHMTs).	• MoHW healthcare delivery is through DHMTs. MLG also delivers some services. • There is joint planning and monitoring of healthcare service delivery by the two ministries at district level. This is guided by the planning handbook, 2002. • Surveillance at the sub national level, collecting data and submitting to MoH, multi-sectoral approach, treatment and prevention. • Health system in Botswana is a decentralized model with PHC being the pillar of decentralization. Botswana has an extensive network of health facilities in the 27 health districts, including 101 clinics which can cater	• Responsible for implementation of the NCD strategy. It is supposed to use a multi-sectoral approach to strengthen the health system for the prevention and control of NCDs. However, there is limited action on the implementation of the NCD strategic framework due to a multiplicity of factors. • **Health Services Delivery**: The districts and local authorities previously used to be responsible for PHC service delivery. Since revitalization of PHC in 2010 these services are now provided by DHMTs which report directly to the central MoHW (see Chapter 4).	**Interviews:** Official from Central District (D1 Cen DH). Official from Kgatleng District: (D1 DH Kgatle). Official from Ngamiland District. (D1 DH NGAM). **Documents:**

	for inpatients, 171 clinics without beds, a further 338 health posts and 844 mobile clinics. • MoHW provides PHC services through DHMTs. DHMTs are responsible for running a network of health facilities.	• Each district has a district health team led by a public health specialist who is responsible for the administration and supervision of a number of public health-orientated diseases such as tuberculosis and HIV. Each district has an average of 3 or more posts for health promotion officers depending on the size of the district. • Overall, the delivery of NCD services is constrained by various factors, notably at PHC level. • Inadequate and ill-equipped healthcare facilities were reported to be the most common issues hampering PHC service delivery. • Limited knowledge about NCDs at PHC level with limited NCD management skills and limited knowledge of the country's NCD strategy. • **Healthcare workforce**: Shortage of trained healthcare staff. • Physicians at primary healthcare facilities are only available in some districts, while nurses and healthcare assistants are the key professionals for NCD services, without sufficient training. • **Health Financing**: Inadequate funding/budget support from the national healthcare programme for effective NCD services and care at the PHC level. • **Access to medical products, knowledge and technologies**: weak supply-side for prevention and management of NCDs widely reported by the participants, so limited products which are vital for diagnosing and treating NCDs. • PHC facilities face medicine stockouts of more than 6 months for high blood pressure and DM. This shortage of medicine and basic diagnostic facilities at PHC facilities limit effective response	• Botswana Health Policy 2010. • Botswana Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023. • Botswana National Policy on HIV/AIDS 2012. • Botswana Mid-term Review 2020 • Botswana Alcohol Policy. • Alcohol Levy, 2008. • Newspaper articles. • District Planning Handbook. • Reports.

		and patients have to switch to other treatment regimes. • **Health information system**: Weak HISs for detecting, treating and monitoring patients with NCDs in PHC settings. • **Leadership and governance**: Weak leadership and stewardship in the management of NCDs in PHC. • A lack of coordination among stakeholders and departments in implementing nationally designed NCD programmes/interventions. • Weak interdepartmental coordination between various government departments, which results in poor NCD outcomes at PHC level. • Failure to use structures that were effectively used in the response to HIV/AIDS, such as DMSACs and VMSACs.	
Traditional Doctors	• Although not part of the modern healthcare system almost all traditional health practitioners (95% of 3100 registered as complementary/alternative medical professionals under the Medical, Dental, and Pharmacy [Amendment] Act of 1987) reside in rural areas where they command a lot of influence and respect among the majority of the rural population.	• Registered under the Dingaka Association. Only those registered with Dingaka Association are considered as relevant stakeholders by the MoHW. • Carry out consultations for NCD patients and prescribe alternative medicine. • Controversy surrounding their practices especially regarding the myths surrounding HIV/AIDS.	**Interviews:** (D1 Dingk)
Youth Council	• They serve as the voice of the Youth. • Used to be an NGO and after there was maladministration at the Council, a decision was made to make it a department under the Ministry of Youth, Gender, Sports and Culture. • Active in HIV/AIDS awareness campaigns. • Participates in the DREAMS project (Determined, Resilient, Empowered, AIDS Free, Mentored and Safe), a partnership to	• Although they are recognized as a relevant stakeholder, they were not consulted or involved in the development of the NCD Strategic Framework. • Their programmes and projects centred around the response to HIV/AIDS and not NCDs. • Their community views NCDs as the diseases of the elderly.	**Interviews:** (A1 Youth) **Documents** • Website portal. • Botswana Multisectoral Strategy for the

	reduce HIV/AIDS among adolescent girls and young Women.		Prevention and Control of NCDs. • Digital media platforms. • Botswana Health Policy 2010.
Donor and International Agencies and Development Partners	• Providing funding and identifying funding opportunities for further implementation of strategy; providing technical support for implementation and addressing gaps in implementation; supporting global advocacy for resourcing of Botswana's efforts and sharing Botswana's experience.	• Limited participation in NCDs with no funding. • Set partnerships with the Government of Botswana to respond to NCD-related diseases. • Their role is limited to providing technical advice and not financial.	**Interviews:** RUTGERS University (Rut 1). European Commission: (AGE 2 EC). Two Officials from WHO: (AGE 3 WH). Other Agencies which I contacted but was not able to interview. (USAID, SADC and UNDP). **Documents:** • Website portals.
Private Sector (business)	• Providing funding and identifying funding opportunities to support national efforts. • Providing technical support for implementation and addressing gaps in implementation. • Developing the minimum package of wellness services for employees.	• **Medical Insurance**: They have contributed positively and negatively to public health through medical aid insurance schemes. • **Profit motive**: The medical aid insurance schemes are driven by profit motive and do not publicly cover NCDs; payment is mainly out of pocket (OPP). • There are instances where the private sector has not operated in the public interest. • Conflict of interest between public health good and business interest.	**Interviews:** Official from BOMAID (P1 Boma) Official from Pharmaceutical Association. (P1 Pha) Official from the Alcohol Association.

			(A1 Alc) Official from Med Rescue International. (P1 MR) **Documents:** • Website portals. • Organizational annual reports.
Profit-oriented private sector service providers		• Resistant to alcohol levy and even labelled it as "Jihad" and government war on fun. • Their role is focused on the business aspects of liquor and not on the health side. • No cordial relationship with MoH. • They were not consulted when the National Strategic Framework on NCDs was developed. • Their participation is mainly on Corporate Social Responsibility (CSR) and marketing.	Website portals: KBL Kgalagadi Breweries Ltd ♦ Botswana, Gaborone (beverage-world.com). Business Botswana :: Home (bb.org.bw). Newspaper portals: website: (Sechaba, Gov't could strike deal over alcohol levy | Sunday Standard), (Botswana's alcohol levy under the radar: do we have policy options regarding unrecorded alcohol Mr. President? | Sunday Standard), (What has happened to money from the alcohol Levy? | Sunday Standard), (Alcohol Levy is a glaring testimony of Khama's failed economic

			policies | Sunday Standard). (Government to hike alcohol levy | Sunday Standard). (Beer Drinking and Tax Levy in Botswana | International Society of Substance Use Professionals (issup.net).
Not for profit private sector service provider - Motor vehicle insurance fund		• Work on regulatory framework, road accidents and injuries. • Works closely with the Ministry of Transport and Communications and Corporations and serves as its secretariat on the road accident fund. • Manages the Roads Accident Fund.	**Interviews:** Officials from the Motor Vehicle Insurance Fund (P1 MVA). **Documents**: • Newspaper articles. • Website portals

Botswana's NCD response is guided by the Multisectoral Strategy on NCDs 2018-2023, initiated by the Ministry of Health and Wellness. The strategy recognises the centrality of multi-sector engagement and proposes the integration of NCD control into communicable disease prevention and control using existing primary healthcare platforms such as HIV, disease surveillance, community health services, maternal and child health, school health, TB and Malaria (p.5). Responsibilities have been divided into curative and preventive, with the former being the primary responsibility of the Ministry of Health and Wellness and the latter the responsibility of the reconfigured National AIDS and Health Promotion Agency (NAHPA). My analysis has revealed that both these institutions have faced challenges in implementing their mandated responsibilities.

The Ministry of Health and Wellness is tasked with the overall responsibility of being the steward, or '*Kaitiaki*' to use the New Zealand term, of the health system in the country, but its response to NCDs has been met with a host of challenges including weak leadership and governance, poor management of NCDs in primary healthcare, lack of coordination among stakeholders, and a failure to repurpose the structures used in the HIV/AIDS response. Medicine stockouts, inadequate budgets, lack of funding locally and externally have also acted as impediments in the NCD response. At a decentralised level, there appears to be more potential, however this is tied up with the realities (and constraints) of how NAHPA and the Ministry of Local Government operate at the primary healthcare level.

NAHPA's reconfiguration was intended to prioritize NCDs and ensure action for the implementation of the NCD strategy. However, the study findings show that despite efforts to integrate NCDs into the national policy agenda and its resulting structures, little progress has been made in building multi-sectoral collaboration or implementing decentralized NCD services. Indeed, decentralization and multi-sectoral coordination for NCD services do not really exist, with little action as NCD programmes have not been integrated into HIV and PHC programmes, for a variety of reasons. Unlike the response to HIV, leadership and coordination across sectors and actors have not been effective because of fragmentation and power struggles, which impede the ability of different agencies and levels to work together in a combined manner. Although there is a dedicated NCD Prevention and Control unit with staff at the NAHPA, respondents commented on the high degree of structural variation at national and sub-national levels, coupled with the

shortage of trained manpower at NAHPA, which led to the transfer of two staff members from the Ministry of Health and Wellness NCD unit to NAHPA in order to establish the NCD unit and other structures. A further part of their mandate is to make sure there is effective collaboration between NAHPA, the Ministry of Local Government and Rural Development, and with the MoHW, which has direct links with the DHMTs responsible for PHC. However, the study findings indicate that there is poor coordination, poor and ineffective leadership, haphazard responses, and a lack of transparency at NAHPA, as well as extending invitation to some NGOs to serve in the Technical Working Groups (TWGs) whilst excluding others during the development of the Botswana Multisectoral Strategy on the Prevention and Control of NCDs; these factors have all contributed to the failure to implement NCD policy, both curative and preventive.

My analysis has shown how the power struggles between the MoHW and NAHPA have further exacerbated the fragmentation of the national response to NCDs. This fragmentation is mirrored at the district level where the Ministry of Local Government and Rural Development has not managed to repurpose the decentralised structures that were so successful in the HIV/AIDS response. So, while decentralization of health services has led to greater responsiveness and adaptation to local needs, preferences, and capacities in the response to HIV/AIDS, this is not the case with the response to NCDs. The weaknesses of sub-national NCD structures are linked in part to capacity constraints. Task shifting and a lack of trained human resources to deal with NCDs at the MoHW, NAHPA, DHMTs, and the Ministry of Local Government and Rural Development were also cited as impediments to the response to NCDs and risk factors. The fragmentation of roles and responsibilities at the district level also plays a significant role in limiting NCD responses.

In an attempt to revitalise PHC services in 2010, the MoHW assumed the responsibility for PHC service provision through the DHMTs. Previously, this function was the responsibility of the Ministry of Local Government and Rural Development, and the DHMT was a department under the city/town and district councils. NCD-related activities are meant to be presented in district development plans and annual work plans of both the Ministry of Local Government and Rural Development and the DHMT (as mandated by the Government of Botswana District Planning Handbook 2002). However, respondents revealed that no line

budget has been provided to address NCDs at the sub-national level, resulting in poorly resourced primary care and inadequate support to repurpose decentralised HIV/AIDS infrastructure. Participants noted limited government funding for PHC facilities with a disproportionate allocation of scarce resources for NCDs to tertiary care facilities (rather than preventive services at PHC level), and procurement of large, expensive technologies again directed toward the tertiary care sector. Basic NCD services provided at the primary care level need to have a clear budget line.

Overall, my findings have shown there is lack of cohesion between actors, statements, goals and prioritisation, and political leadership. While participants generally perceived the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs as a step in the right direction that signalled the country's political commitment to respond to NCDs, my findings revealed limited implementation and significant challenges. Most participants cited the lack of political commitment coupled with poor leadership in the implementation of NCDs compared to HIV/AIDS and described how this had led to an ineffective response at the sub-national level; decentralized health system structures were inadequately funded and supported to implement the NCD response.

This chapter also revealed aspects of government's interplay with non-government actors. At a policy level, participants noted the exclusion of advocacy groups in the response to NCDs which has also exacerbated a siloed approach, in which some institutions have been developing their own tools and guidelines to respond to NCDs. Multilateral agencies and other donors continue to favour HIV/AIDS and not NCDs. There is a lack of donor funding to support CBO/NGO activities and NCD programmes, for which the small amount of funding from NAHPA is inadequate. Furthermore, the withdrawal of support by CDC and ACHAP due to Botswana's classification as an upper-middle-income country presented a heavy blow to the country. The Merck Foundation has also decreased their 10-year drug donation rate by 90%. These issues, and the role and impact of donors, civil society and other non-government actors are analysed and discussed in the next chapter.

Chapter 6: Non-Government Actors' Networks, Cohesion and Influence: How They Shape NCD Responses in Botswana

This chapter expands on Chapter 5, which discusses the roles and power of government agencies (as the guiding institutions for NCD response) and how their power and influence was translated into action or inaction in the response to NCDs in Botswana. This chapter examines the non-governmental actors who influenced, were involved or are stakeholders in, the response to NCDs in Botswana. It first examines the role of civil society organizations and professional associations, and then the voices of the youth – as represented in the National Youth Council. Next it considers a range of private sector healthcare-related actors, including the medical insurance and pharmaceutical industries and private healthcare practitioners. Following this, the role of international agencies and donors including the extent of their support in response to NCDs is explored with specific consideration given to the technical support – and therefore influence – offered by Rutgers University. Finally, the chapter turns to a detailed examination of the role of the alcohol industry in resisting and weakening the government levy on alcohol, and how its actions shaped NCD responses. I examine the extent to which the industry has attempted to use its power through marketing and lobbying strategies, to influence alcohol policy and the government response to NCDs. This section also examines how the industry attempted to use economic arguments to challenge government policy and to raise public support for its own arguments.

6.1. Civil Society Organizations and Professional Associations

6.1.1 Civil society organizations

This section examines the role of civil society organisations (CSOs), and professional associations (representing many private sector healthcare providers), as potentially important policy actors that could contribute to shaping and implementing NCD responses. I assess the contribution of CSOs and professional associations to creating a cohesive policy community that could generate political attention and action in the response to NCDs. This chapter discusses civil society organisations, such as BOCAIP, LEGABIBO, BOSASNET, and professional medical associations including the Diabetes Association. All these institutions are discussed here within

the context in which they contribute to the efforts to respond to NCDs and risk factors.

In Botswana, reports indicate that civil society actors played a fundamental role in the response to HIV/AIDS by providing care and support for those who were infected and affected and assisting interventions such as HIV/AIDS information, education, and communication strategies that focused on behaviour change to prevent transmission, (28). The call for the participation of civil society actors in responses to the NCD threat has been expressed in UN Political Declarations and also in the WHO's NCDs Global Action Plan and Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs, 2018-2023.

The participants in this study considered the role of civil society and grassroots organisations (CSOs) to be to mobilize and press national authorities to address health service responses at the national and sub-national levels. However, the study findings indicate that civil society's participation in the response to NCDs in the country has been ineffective due to the dependency of CSOs on donors (who do not prioritise NCDs – this is discussed below), poor coordination and lack of effective leadership.

Most respondents underlined that the donors set the policy agenda and prioritized what had to be done, and their key priority area was HIV/AIDS and not NCDs. This situation, in the respondents' arguments, explains why there has been a minimal response to NCDs by civil society actors – they lack donor funding and related drivers to pursue activities. Some CSO respondents, however indicated that despite this, some donors were making attempts to include NCDs as part of their mandate. Nevertheless, the participants stressed that the limited presence of government initiatives to strengthen the health system to address NCDs, for example by providing national information tools and guidelines, has contributed to a siloed approach with civil society organizations (CSOs) and other institutions developing their own tools and guidelines for an NCD response, which are not in line with the Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs. The study findings show that even where CSO initiatives exist, as outlined in the Botswana NCD Strategy 2018-2023, implementation is limited, in part due to limited capacity and resources.

For their part, CSOs are expected to empower communities and are often considered most effective at reaching marginalized populations given their flexibility and location in remote areas (UNDP, 2003). For instance, the three senior officials from the Botswana Christian AIDS Intervention Programme (BOCAIP) (C1 BCP) stated that many CSOs were involved in the HIV/AIDS response along with multiple donors from within the country and globally, and one respondent from BOCAIP argued for such integration was also needed for an NCD response:

> *"Most of the donors want to see that integration across. So, if you come in and talk about TB and HIV only, you seem to be limping. Therefore, we realized that we were not very efficient in our service delivery. We were left behind in terms of what the donor community really wants, and left behind in terms of what the government wants to achieve in terms of delivery of health services right now – it decided to also integrate NCDs into its programmes, because we had realized that now it's NCDs which are actually taking people's lives, more than HIV itself and also more than TB."*

For these respondents, although they acknowledge that NCDs are the leading cause of mortality and morbidity in the country, their response is however constrained because of donors who fund the agenda. The funding CSOs that receive is primarily from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and USAID, which both mostly cover HIV/AIDS and not NCDs. The study participants from civil society actors stated that they did receive funding from within the country, from NAHPA for their projects and programmes, but the sources of funding are split into two, with southern regions sponsored by external donors and northern regions funded from NAHPA. Although the respondents from civil society were not asked why this funding was divided between these two areas, it became apparent that the government no longer receives sufficient funding from donors as it used to do and that NAHPA funding was more limited than that of the donors.

According to civil society interviewees, most of their programmes are still focused on HIV/AIDS and tuberculosis and not on NCDs, although some of them have recently integrated NCDs into their HIV programmes following recent recommendations from funders who set the agenda on what has to be done, when, and how:

> *"So, like we said we are not providing NCD services as a direct project, we have integrated NCDs within our HIV programmes, most of our programmes are HIV and tuberculosis. So, we have integrated it just like we have integrated gender-based violence in our programmes. So NCDs come in as an add on. So, that is why [this is] the only thing that the funders are doing when it comes to NCD*." (Three Senior Officials from BOCAIP (C1 BCP)).

The respondents also gave examples of other NCD actions. CSOs' "harmful use of alcohol intervention programmes" were supported by funding from the government Alcohol Levy, via the MoHW. They also spoke of collaboration with the Debswana Mining Company to carry out screening for NCDs in the small mining town of Jwaneng in southern Botswana, to augment government efforts in responding to NCDs by ensuring the early detection of these conditions.

The findings also show that there is one local NGO (Botswana Cancer Association) entangled in a corporate governance dispute which has led to court action. The NGO's Board of Governors filed a case against a senior official from the NGO at the high court, and stressed that despite the MoHW and NAHPA being alerted about the maladministration as well as flaunting of organisational rules and regulations, leading to an abuse of office at the association, the senior official from the NGO had received preferential treatment. The Board of Governors stressed that the actions by the senior official had the potential to damage the NGOs' reputation, more so because the NGO is the first of its kind to be established in the country and it had received donations to construct a cancer screening centre, a project which had been undermined by the senior official's actions. Furthermore, the Board of Governors indicated that when the senior manager was hired, their sole responsibility was to change the NGO into a more reputable and effective organization, but now the opposite had happened, with the senior officer claiming that the NGO is their own personal property. Although the Board of Governors were not asked about the dynamics of the preferential treatment and what that meant, it was clear that they felt there was an element of corruption between the MoHW and the senior official. This NGO has been receiving funding from NAHPA amounting to 2.8 million Pula (US 255,000), and the funds were intended for and used for training and to carry out awareness and educational campaigns on cervical and breast cancer. The senior official from the NGO said that the NGO had

received this funding because of their hard work, hence the dispute and entanglement with the Board.

This particular case has wider ramifications for funding of NCD responses, especially for cancer, because of the thinking that funding received from NAHPA may open windows of opportunity for corrupt practices, and so those funders supporting NGOs may shift their funds and noble gestures elsewhere.

Other interviewees from BOCAIP stated that their role as an NGO is to augment government efforts, and stressed that they are funded by different donors. BOCAIP's focus is on the HIV/AIDS response. It was initiated by the Christian community in order to contribute to the fight against HIV/AIDS through a Christian approach. BOCAIP is governed by a National Board whose role is to provide strategic guidance to the effective functioning of the organization. The three respective officials from BOCAIP stated that, as a civil society organization, they are not actively involved in the response to NCDs and stressed that it will always remain the MoHW's responsibility:

> "*So, that's our role as an NGO and to augment government efforts to make sure there is early detection of these conditions. (Inaudible at 06.22), and we were funded by five different donors to implement these services. Currently, our donor is USAID. So as long as civil society is not actively involved in the response to NCDs, it will always remain a Ministry of health problem, and not a community problem*." (C1 BCP).

The interviewees from civil society organizations described the need to join forces with private sector healthcare providers (many of which are represented by professional medical associations) to get NCDs on the agenda, but seemed to find limited opportunities to do so.

6.1.2 Professional medical associations

The official from the Diabetes Association (D1 DIA Assoc) emphasised the absence of well-organized and integrated national response tools and guidelines that specifically address NCDs. The interviewee noted that although the MoHW NCD Unit is the custodian of all NCD responses, cervical cancer is not part of this but has its own separate unit or section; such fragmentation of structures leads to the development of separate toolkits and guides for each individual NCD:

> *"Looking at how NCDs are organized within the Ministry of Health has been a challenge. […] So, what would happen is, you know, hypertension or diabetes would have its own guiding documents and then cervical cancer has its own, and then other cancers would have their own guiding documents so it will be pieces and pieces. […] if you look at the NCD Unit, it's a custodian of all the NCDs but cervical cancer is not part of that, it's in a different unit or section."* (D1 DIA Assoc).

Furthermore, Diabetes Association official (P1 DIA Assoc) revealed that as an association, they decided to develop their own tools and guidelines on diabetes, mainly because national guidelines are not available. In developing their own tools and guidelines, they did not consult the MoHW and NAHPA, mainly because of poor coordination and effective leadership from NAHPA. There is also limited funding to enable them to carry out the nationwide educational campaigns that they do once a year, separate from those carried out by the MoHW and NAHPA. As a result, they decided to adopt the siloed approach mainly because of the inadequacy and poor leadership of the MoHW as a guiding institution:

> *"What we have done is that out of our own initiative, we do those campaigns and drives just out of what we could do. So, we have never really sat down and engaged the state or anybody else on how to tackle this. We never put it forward as a national issue per se, it was always a lone issue that nobody ever really put effort into."* (P1 DIA Assoc).

Nevertheless, the participants stressed that despite the siloed approach, they gave regular reports to the MoHW and NAHPA on the scale and magnitude of diabetes in the country.

Two actors have coalesced around cancer: the Cancer Association and Journey of Hope, which collaborated to carry out their own advocacy specifically on cancer. They also recognize a shared agenda around the response to cervical cancer. However, despite this collaboration, there are tensions and conflicts about funding. The study findings indicate that when funding is disbursed by NAHPA to Journey of Hope to carry out cancer awareness campaigns, training and treatment, the Cancer Association felt neglected as it wanted to be the one receiving the funds, leading to some animosity.

There is also tension between the Botswana Medical Aid Society (P1 BOMA). The official from the Botswana Medical Aid Society (P1 BOMA) interviewee held the view that, as a professional association, they are probably doing a better job than the government (which maybe therefore sees them as a competitor), but the government never consults them:

> *"The thing is the Ministry of Health and Wellness never consult us. I think they see us more as a competitor than a good partner [...] We are also performing much better than them."* (P1 BOMA)

They further indicated that even if they were invited to the MoHW stakeholder consultative meetings or were to be made part of the thematic working groups, that would just be a public relations exercise by the MoHW, carried out to tick a box by the MoHW and thus give an impression that they were consulting and engaging with different stakeholders, while in reality they were not. The respondent from Botswana Medical Aid Society (P1 BOMA) stated the following.

> *"I think the industry (Botswana Medical Aid Society) is doing a better job, and obviously AIDS is not an NCD, but outside of that, I think, the private sector is probably doing a better job than government*."

The professional association interviewees indicated that they and private sector healthcare providers can play a meaningful role in the response to NCDs and risk factors as relevant stakeholders, and could be quite robust in doing so if compared to the government. They stressed that although the government tries to respond to NCDs and risk factors, there is no direction in how implementation is to be carried out:

> "*At this moment, it is simply talk. However, they do not know how they really want to do so. I think they're struggling [...] and that's where sometimes you really want to come in and help, because government will throw money at it, and then they hope the problem will go away, so there's no monitoring and evaluation*." (P1 BOMA).

The professional association interviewees stated that meaningful partnerships between them and the government could be established to enable interventions. An interviewee from the Botswana Medical Aid Society (P1 BOMA

) indicated that they felt the government was really struggling to align NCDs with the SDGs and national strategic framework and called for some of the activities to be outsourced to private sector providers as a cost-cutting measure:

> *"I think this area [NCD service delivery] is the one area that can be easily outsourced and driven through the private sector and the civil society movement, because they can be quite robust in their service delivery when you compare it with the government. So, partnerships can be strengthened, number one, so government could maybe, you know, outsource through partnerships, more than anything, and this can be done as cost effectively as possible."* (P1 BOMA).

6.2 The Botswana Youth Council: Disengaged from NCDs

Another important grassroots voice to consider in the national NCD response is that of the youth – whose behaviour now will affect their susceptibility to NCDs later. In Botswana, the youth are not represented by CSOs or an umbrella NGO body, but by the Botswana National Youth Council (BNYC), which sits under the Ministry of Youth, Gender, Sports and Culture. The Botswana Youth Council is responsible for lobbying and advocating for development policies and programmes affecting the youth, as well as to give advice. It serves as the voice of youth in the country. Previously it was an NGO but was disbanded and made a government department after maladministration and embezzlement of funds. The Youth Council is now dependent on the Ministry of Youth, Gender Sports and Culture where they are housed.

Adolescents (10–19 years' old) are especially vulnerable when exposed to various unhealthy behaviours as they transition to adulthood (Patton and Sawyer 2016). Therefore, it is imperative for young people to understand NCDs and their risk factors, such as tobacco use, harmful use of alcohol, physical inactivity, and unhealthy diets. In Botswana tobacco use is typically the most common among those youth whose close family smoked (109), (110). Parental smoking may exert its influence on adolescent smoking through various mechanisms, including the availability of cigarettes in the home environment, modelling, and parents' difficulty in enforcing sanctions against smoking when they also smoke, (109). The study participants from the MoHW stated that the tobacco industry has begun to directly target youth and women, especially through social trend shifts and

marketing efforts with the introduction of “hubbly bubbly pipes” and vapes in restaurants and night clubs. Interviews with the Youth Council representative (A1 Youth) and related documents revealed that with respect to alcohol use, young school-going boys and girls are current alcohol users.

The study findings reveal that in Botswana, NCDs are framed differently by the youth, who perceive NCDs as diseases of the elderly that do not affect them. As a result, their programmes and initiatives are predominantly focused on the response to HIV/AIDS and not on NCDs (A1 Youth). While the Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs (2018-2023) is considered a blueprint for an effective response to NCDs and risk factors in the country, the youth representative stressed that they were not involved, and youth were not represented when the strategy was developed (A1 Youth). Furthermore, their parent ministry, the Ministry of Youth, Gender, Sports and Culture, has equally not played a part in mobilizing the youth by giving them bureaucratic and political support, despite having a mandate to do this. This is because NCDs have not been a priority for this Ministry as most of their youth programmes are focused on HIV/AIDS and not NCDs. Similarly, there is an annual funding call for youth projects from the NAPHA on the DREAMS and Safe Male Circumcision projects among those working closely with international NGOs and the private sector. DREAMS is also based on the HIV/AIDS response and not on NCDs. The youth representative stated the following:

> *“According to BNYC, youths are ignored in the response to NCDs and risk factors, and more education is needed to sensitize the youth as currently the only time they engage with the Ministry of Health is when dealing with HIV/AIDS issues and not NCD.”*

The Youth representative stated that there is an imperative, a need, for them to focus their attention on NCDs and not only on HIV/AIDS, so that many young people today can obtain unprecedented access to information and act to prevent NCDs, and so determine their health status.

6.3 Private Sector Healthcare Actors

The UN Political Declaration of 2011 came with the hope of garnering multi-sectoral commitment and facilitating action to include the private healthcare sector in the

NCD response. In Botswana the private healthcare sector is diverse and encompasses medical insurance companies, private healthcare service delivery facilities, and pharmaceutical companies and outlets. All need to make a profit from their activities.

6.3.1 Medical health insurance and private practitioners

This section discusses the role of medical health insurance actors and private healthcare practitioners in the response to NCDs and risk factors in the country. The study findings indicate that although the private healthcare sector is multi-faceted and diverse, it does not significantly contribute, either positively or negatively, to the NCD response.

The private medical insurance companies are responsible for providing health insurance coverage for their members who are covered to pay medical fees and only pay out of pocket for any fee difference above that specified in the policy. However, as discussed below, there are discrepancies with medical health insurance cover for NCDs, where those insured are expected to pay out of pocket. There are often instances when medical insurance cover is insufficient to cover the costs of longer admissions in private hospitals and clinics, which often leads to patients being transferred to public health facilities, especially for NCD patients where quality health care is insufficient.

Participants from the Botswana Medical Aid Society (P1 BOMA) argued that they and other private sector actors faced challenges in engaging and collaborating with other stakeholders and the government, with regard to aligning their objectives, coordinating actions, and sharing information and best practices on how to effectively respond to NCDs. Furthermore, the respondent from the medical insurance company (P1 BOMA) stressed that they provide better services than the government, but however, stressed that they are never engaged as relevant stakeholders by the government; they therefore find it difficult to demonstrate their value in managing NCDs both in terms of health care services delivery outcomes and economic cost cutting measures.

Participants from the medical insurance companies indicated that they are mostly seen as competitors by the government rather than relevant stakeholders that can meaningfully contribute to the response to NCDs. The insurance sector

interviewees also indicated that lack of consultation was a serious concern to them because they felt that their expertise was disregarded, yet they felt they could be making a meaningful contribution. Nevertheless, private sector providers ultimately face profit-making challenges due to inadequate financing and access to public financing mechanisms for NCDs, and because private medical insurance companies do not cover NCDs – most payments for NCD care come from out-of-pocket payments.

The study findings also show that the private healthcare facilities face shortages of qualified and skilled healthcare workers who can deliver NCD services and products, and that these staff are mainly centrally located, so that staff shortages are especially severe at the sub-national level and in remote areas of the country. As a result, the study findings indicate that public health facilities are delivering NCD services to the holders of private insurance schemes, but in these public facilities there is also a shortage of trained specialists to deal with NCDs. In some districts, there are no family medicine practitioners, coupled with a shortage of diagnostic equipment. The private sector must, therefore, invest in the training and capacity building of health workers to ensure the quality and safety of NCD services and products.

The private sector also faces challenges in ensuring adequate and reliable supply of essential medicines, vaccines, technologies, and equipment for NCD prevention and care. There are also frequent stock-outs at public health facilities, leading to crime syndicates and stealing of drugs from the Central Medical Stores (CMS) to sell to private sector providers. The private sector also faces difficulties in accessing and maintaining adequate physical infrastructure, such as facilities, transport, and communication, which are necessary for delivering NCD services and products, especially at the sub-national level.

The Journey of Hope, (C1 JO HOP) and Cancer Association (C1 CA A) respondents stressed that the private hospitals and medical healthcare facilities have encountered resistance and mistrust from some stakeholders, who perceive the private sector as having mainly profit motives for addressing NCDs. A cancer patient cannot be hospitalized for more than a month using his/her medical insurance scheme, and once funds are depleted, the patients are transferred to a public health care facility, where quality of care is considered poor or it takes a long

time to be attended to, leading to deterioration of the situation, and being discharged before getting full medical attention and care. The respondents from The Journey of Hope, (C1 JO HOP) and Cancer Association (C1 CA A) argued that this is also attributed to shortages of trained medical specialists and oncology nurses at public health facilities.

According to the Pharmaceutical Association (P1 Pha) respondent, the Business Forum (Business Botswana), a private healthcare forum, has also acted as an impediment to private sector participation and thus hindered an effective response to NCDs. The respondent from the Pharmaceutical Association (P1 Pha) stressed that Business Botswana, the private sector forum, did not have in place a detailed strategic framework or policy guide on how they intend to respond to NCDs as a responsible forum representing the private sector. Furthermore, they stressed that the head position of the forum is a voluntary position, and the person overseeing the portfolio was overwhelmed as they are also running their own practice.

The participants from the Botswana Medical Aid Society (P1 BOMA) stated that although BOMAID is referred to as a participant in the Botswana Multi-sectoral Strategy for the Prevention and Control of NCDs, 2018-2023 (as a participant in its development), this was not the case. The participants stated that they were interested in participating as a relevant stakeholder and had an interest in assisting their members to have access to affordable and quality care for NCD treatment, without patients necessarily having to pay out of pocket. They stressed that this goal can only be achieved if the government does not look at them as competitors.

> *"So one of the challenges that we are faced with is to try and find a way to help our people to be able to access the treatment without necessarily having to pay anything out of our pockets. So, you hope that someday somebody will come with some research or some inventions that can make it more affordable for people to access oncology, oncology treatment."* (P1 BOMA).

They stressed that it was frustrating that they could not meaningfully participate and offer ideas on how to respond to NCDs with the MoHW as well as NAHPA.

6.3.2 Pharmaceuticals Association and Industry

The participants from the Pharmaceutical Association (P1 Pha), a professional body of pharmaceutical practitioners (pharmacists) in the country, indicated that whilst they do not have direct links to the policy development process in the response to NCDs, they have indirect links as some of their members form part of the Business Botswana forum, which *was* responsible for the private sector healthcare involvement in policy development. The participant from the Pharmaceutical Association (P1 Pha) stressed that a big challenge for the NCD response is the frequent shortage of drugs for NCDs, which are highly needed by patients at health care facilities, both at the national and sub-national levels. As a professional body of pharmacists, they stressed that while the country has frequent stock-outs of NCD medications, their main concern was also that the shortage has been exacerbated by the eruption of crime syndicates in the country, which steal drugs from public health facilities and the Central Medical Stores (CMS). These syndicates have allegedly been selling the stolen medical drugs to physicians and private pharmaceutical companies, hospitals and some to neighbouring counties acting in league with public servants, creating serious problems for the supply of drugs.

Thefts of HIV drugs (ARVs), hypertension and diabetes drugs were also reported by Nicholas Mokwena from the Botswana Guardian newspaper, dated 16th June 2023 (PressReader.com - Digital Newspaper & Magazine). The Guardian reported that Botswana has since March 2022 been battling a shortage of medication at public health facilities, a problem that has particularly affected children and those who suffer from chronic diseases and require constant medication. According to the Guardian report, several other factors have been cited as contributing to the medicine shortages in Botswana. One was the lack of funding for the procurement of medicines, with the government accused of failing to allocate enough money to purchase medicines. In addition, there were delays in the delivery of medicines from other countries due to COVID-19 which made it even harder for pharmacies to stay stocked up on essential medications.

The Botswana Guardian reporter, Nicholas Mokwena, wrote that a joint operation by law enforcement agencies (Directorate on Corruption and Economic Crime (DCEC) and Directorate of Intelligence and Security (DIS) had resulted in the arrest of 10 people in relation to the theft of medical drugs. The first suspect to be arrested

was found in possession of drugs and money amounting to (US$ 7454). Another man was arrested for transporting and selling ARVs, hypertension and diabetes drugs stolen from government clinics. Others arrested included nine civil servants, inclusive of pharmacists and nurses. As a result of this stealing, the MoHW issued a statement indicating that it regrets the possibility that some of its staff could have been involved in stealing medications meant for the public (PressReader.com - Digital Newspaper & Magazine).

Participants from the Pharmaceutical Association (P1 Pha) stated that a shortage of drugs may require patients to switch to another brand or to different drugs, thus interrupting their prevention or treatment regime. DHMT-level respondents noted the same concerns, as discussed in Chapter 5. The respondents from the DHMT indicated that in the worst-case scenarios, patients may go without medication for a long period of time, which can increase the risks related to their condition. Participants from the Pharmaceutical Association stressed that the ongoing shortages of many diabetes and high blood pressure medications have serious implications for people with these conditions, who must live with uncertainty as to whether they can access the best course of treatment. Respondents added that drug shortages impose other burdens for patients, as some now travel long distances across the country to the capital city, Gaborone, in the hope of finding prescriptions.

The other major concern raised by the participants was the issue of pricing, and the underground cartel engaged with price fixing and sometimes acting and working in league with physicians.

Overall, respondents referred to the unprecedented shortage of medicines in the pharmaceutical industry, public health facilities, and CMS, which causes worry to patients, extra costs, and has endangered patient health and even lives.

6.4 International Agencies, Foreign Research Groups and Donor Support for NCDs: Opportunities and Constraints.

This section provides a narrative of how international agencies, foreign research groups, and donor funding have assisted in shaping the policy development agenda in response to NCDs and risk factors in the country. The section also examines the discrepancies and the lack of incentives provided by international

agencies, donors, and foreign research groups for the response to NCDs, compared to their response to HIV/AIDS. The section also discusses the partnerships engaged in research to help advance the national programme on cancer as well as to create joint research training.

Botswana is a globally well-known case study for its effective response to HIV/AIDS, through the favourable support of the international community, donors, multi-lateral agencies and NGOs. The findings of this study show that unlike HIV/AIDS, NCDs have not attracted similar funding and donor participation, both globally and nationally, which has hindered the national response. Although NCDs were first included in the National Development Plan 11 (Eleven), as recommended by the Political Declaration on NCDs 2011, this has not been supported by financing (and incentives) to respond at the national and sub-national levels. Donor participation and research groups are discussed in this section to assess their level of contribution and support in response to NCDs, compared to what they did in the HIV/AIDS response.

For the HIV response Botswana received large-scale support through partnerships such as the African Comprehensive HIV/AIDS Partnerships (ACHAP), making the country the first one in the continent to offer free ARVs to its citizens. Reports indicate that ACHAP is a public-private partnership involving Merck and its related Foundation, the Bill and Melinda Gates Foundation, and the government of Botswana.

Botswana also received large-scale support from the Botswana Harvard Partnership (BHP). BHP is a collaborative research and training initiative established by the Government of Botswana and Harvard University in 1996. The BHP also houses the Botswana–Harvard HIV Reference Laboratory, the largest HIV/AIDS laboratory in Africa, which serves as the reference testing laboratory for all AIDS activities in Botswana. BHP is an NIH-funded Clinical Trials Unit site for various trial networks, including the HIV Prevention Trials Network, AIDS Clinical Trials Group, International Maternal Paediatric Adolescent AIDS Clinical Trials Group, and HIV Vaccines Trial Network (Botswana-Harvard AIDS Institute Partnership (BHP) – HBNU Fogarty Global Health Training Program). Botswana also has a partnership with the University of Pennsylvania which has worked in Botswana since 2001. The Botswana-UPenn Partnership works with the Government of the Botswana Ministry of Health and the University of Botswana to

build healthcare and research capacity in Botswana. According to the UPenn website portal, the University of Pennsylvania train healthcare personnel throughout Botswana in the treatment of HIV/AIDS and its complications to help develop post-graduate training programmes at the University of Botswana, with an emphasis on Internal Medicine and its sub-specialties, to offer experience in global health to Pennsylvania trainees, and to develop joint research programmes that address issues relevant to the health and welfare of the citizens of Botswana (Botswana-UPenn Partnership | Perelman School of Medicine at the University of Pennsylvania).

While partnerships have been forged with foreign research groups and international agencies to support the response to HIV/AIDS, there are few that support the response to NCDs. Moreover, their support has not translated into financial support and NCDs have not received the same financial and political support from the global health community as HIV/AIDS. While the first UN General Assembly Special Session (UNGASS) for NCDs in 2011 aimed to stimulate donor funding and political action, the study findings indicate that only a small percentage was allocated to NCDs in 2015. By comparison, the UNGASS 2001 on HIV/AIDS raised large sums of money for HIV within a relatively short period and enabled millions of HIV-infected individuals to access antiretroviral treatment.

Participants from the MoHW stated that although they do not receive as much support for the response to NCDs as they did for HIV/AIDS, nevertheless, some of the development partners, namely the EU Commission, UN agencies, WHO, and USAID, have played an important role in the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs, 2018-2023. They have been providing technical assistance, that is Technical Working Groups (TWGs), and providing guidance. In Botswana the two primary foreign actors supporting the NCD response are Rutgers University and the Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JPIEGO). Rutgers University has even signed a memorandum of agreement with the Government of Botswana; I consider this in more detail in the next section.

The European Commission is also a significant development partner operating in Botswana together with USAID and others. The participants from the European Commission stressed that the development partners consulted with the

Government of Botswana and in doing so agreed on certain indicators and key priority activities in line with the National Development Plan Eleven (NDP 11), including health. According to the study findings, there are a number of these developmental partners operating in the country such as USAID whose focus is also on health, more specifically HIV/AIDS, but not on NCDs.

6.4.1 Rutgers University

The study participants from Rutgers University explained that in August 2018, the Rutgers Global Health Institute engaged with Botswana's leadership, including the MoHW and the University of Botswana, to identify opportunities for global health partnerships. Building upon these efforts, Rutgers and the Government of Botswana signed an agreement to launch the Botswana-Rutgers Mahube Partnership in February 2019. Mahube means 'new dawn' in Botswana's local Setswana language. The partnership is led by Botswana President Mokgweetsi Eric Masisi and Rutgers President Robert L. Barchi.

The study findings also indicate that the State University of New Jersey established a memorandum of understanding with the University of Botswana to: help advance the national programme on cancer care and prevention; create joint research and training programmes to improve cancer care and prevention; create local, sub-specialty medical and health professional training programmes; and expand national health care capacity and advice during the commissioning of Sir Ketumile Masire Teaching Hospital, a new academic teaching hospital in Botswana.

According to the respondents from Rutgers University, the Rutgers partnership arose as a result of the numerous meetings between the President of Botswana and President of Rutgers university, led by the Director Rutgers Global Health, Professor Richard Marlink. Building on his years of involvement in Botswana's HIV/AIDS response, he worked with the Government of Botswana and the University of Botswana to establish the Botswana – Rutgers Partnership for Health. Professor Marlink has for last 22 years led partnerships in Botswana to combat HIV/AIDS nationwide together with Professor Essex from Harvard University, which led to the establishment of the Botswana Harvard partnership.

Rutgers respondents (Rut-1) stated that currently, the Sir Ketumile Medical School is working with the MoHW. They stressed that one of the biggest challenges currently faced by the country in the effective response to NCDs and their risk factors is that Botswana does not have sufficient trained oncologists and pathologists in the country:

> *"If you look at health care, in terms of human resource, like you mentioned that we don't have oncologists, pathologists, that's another big issue right now, in terms of how that is managed,"* (Rut 1).

Rutgers has taken on responsibility for training oncology nurses, and is also working on the ground to identify the current needs of cancer in the four centres of cancer care in Botswana:

> *"So, currently we are working with the Ministry of Health [...] so we are starting from somewhere. We have just [...] started collaborating the with the Faculty of Medicine] so that we can train our own oncologists at the School of Medicine, to train oncology nurses. So, other than that, we are working on the ground to identify the current needs of cancer care in the four centres of cancer care in Botswana which are Princess Marina, Nyangabwe, Letsholathebe and Sekgoma. So, we are trying to see what shortfalls there are, to come up with programmes to fill the knowledge gap".*

6.5 Power and Political Economy: The Case of Alcohol Industry Actors in the NCD Policy Response

As can be seen so far in this chapter, in general, the array of non-government actors who have a stake in Botswana's NCD response have been relatively silent, inactive and lacked capacity in relation to an NCD response. All these non-government actors – civil society actors and youth voices, private sector providers and insurers, pharmacy representatives and international donors and foreign agencies – have had limited influence on the response. Compared to the HIVAIDS response, funding and political attention has not been substantial. The one set of non-government actors which *have* significantly shaped aspects of the NCD policy response in Botswana, however, is the alcohol industry. This section discusses the nature of the political context in which alcohol-related actors operate. It examines

their economic power, influence, and social aspects of their activities. It begins with a brief discussion of the structure and organization of the alcohol industry and its network of associations in the country. This is followed by a discussion of the economic and social aspects of the Alcohol Levy. I then examine the policy substitution measures undertaken by the alcohol industry to resist and counter the Alcohol Levy policy.

6.5.1 Alcohol actors and their motivations

The reports and the study participants from the alcohol industry and the Alcohol Division at the MoHW explained that the Botswana alcohol industry comprises a variety of key players, including Kgalagadi Breweries Limited, Global Holdings Botswana, and Diageo-Namibia Breweries, Distell, and Benju. All three are involved in the distribution of beers, ciders, wine, and spirits. The reports also indicate that the industry forms alliances with liquor trade associations in the country, such as the Botswana Alcohol Industry Association (BAIA), Botswana Beverage Association (BOBA) and Business Botswana (BB) to lobby for support.

The study participants from the alcohol industry acknowledged that their role (and therefore motivation) is focused on the business aspect of liquor and not on health:

> *"You see, our role much more was centred around the business aspects of liquor, much, much more than the health side."* (A1 Alc).

These business interests were key to their arguments in opposition to the 2008 Alcohol Levy that the government introduced in an effort to curtail harmful drinking practices, which I will examine next.

6.5.2 The Alcohol Levy: exclusion and controversy

An Alcohol Levy was introduced in 2008 by the former President Lt. General Ian Khama. This levy was introduced to curb the harmful use of alcohol and was imposed on those who sold alcohol and was as a result passed on to those who consumed alcohol by raising liquor prices. Initially when the levy was introduced, the former President set a very high figure of 70%, but following pushback from the industry (who feared their sales would be affected by rising prices) and the general public through the support of members of parliament, the levy was dropped to 55%.

The Alcohol Levy has been deemed extremely controversial as it was a sudden announcement made by the former President. There was never any consultation with relevant stakeholders, as is the norm and the usual practice in the country. Everyone was taken by surprise when the levy was introduced. Ironically unbeknown to the former President on making the sudden announcement, he was not aware that the Government of Botswana was a major shareholder in the alcohol industry through a subsidiary called Botswana Development Corporation, in which the government held major shares.

The Alcohol Levy's administration was moved from the Ministry of Trade to the MoHW, primarily because it was envisaged when the levy was introduced that the money raised would be used to build rehabilitation centres and fund and support those CSOs that were established to deal with substance and alcohol abuse. The MoHW was considered to be better placed to deal with these health issues as opposed to the Ministry of Trade.

When the levy was introduced, according to the respondent from the Alcohol Association Botswana (A1 Alc), the industry lobbied for support from liquor traders and associations and threatened to take the government to court because they felt they had not been consulted as relevant stakeholders. Joining solidarity with the industry, the local print media echoed their opposition to the Levy as did the ruling party backbencher, the elected Member of Parliament Honourable Botsalo Ntuane. The Sunday Standard newspaper labelled the government's action as "Jihad" whilst the Member of Parliament called the new regulations draconian and a "government war on fun". Despite the backlash from the industry, the Government of Botswana introduced the levy in 2008, followed by the development of the Alcohol Policy in 2010.

Following the 2008 lobbying by the industry, there was another phase of intensive lobbying In 2018 by the alcohol industry, whereby it held numerous consultative meetings with government, lobbying to cut the levy again. The interviews and reports indicate that year (2018), the government finally succumbed to pressure from the alcohol industry. Interviews show that Botswana Alcohol Industry (BAIA) representatives of the country's largest producers, wholesalers, and retailers, namely Kgalagadi Breweries Limited (KBL), succeeded in pressurizing the government to reduce the alcohol levy from 55% to 35% as part of its efforts to

attract investors and create employment. When Investment, Trade and Industry Minister Bogolo Kenewendo presented the amendment bill to effect the reduction, he declared:

> "*Under the new regulations local beer producers shall pay a levy at a rate of 35% on the cost of production of such goods when sold for home consumption.*" (Investment, Trade and Industry Minister, Hon Bogolo Kenewendo. (Mmegi, 2019 #185)).

It is also indicated in (111) that when the Assistant Minister of Trade presented this amendment bill for the reduction of the levy, the economic benefits derived from the participation of the industry were emphasised. The Assistant Minister of Trade is quoted by the Mmegi newspaper as having stressed that the Kgalagadi Breweries Limited (the industry's main player) paid millions in taxes and was also the largest employer in the country, therefore the introduction of the levy was contributing to job losses. This observation was again shared in 2020 after the outbreak of COVID-19, which led to the ban on alcohol sales as an intervention measure to control the pandemic, linked to the imposition of lockdowns and preventing people from gathering and socialising together. The study findings show that the industry lobbied for ban to be lifted, with the BAIA threatening to take the government to court over the ban. My interviews show that BAIA's actions were supported by Business Botswana (BB) and the newly established Botswana Beverages Association (BBA) as well as by the Assistant Minister of Investment, Trade and Industry, who also revealed the negative impact of the suspension of trade during this period. The Assistant Minister said:

> "*We had to start with the alcohol industry because of its high risk to Covid-19. Evidence shows that the virus spread where people congregate and the alcohol industry is a major contributor". As a Ministry we work together with the Health Ministry and the Presidential Task Team. We came together, they showed us the numbers and we agreed that we cannot continue to sell.*" (Assistant Minister Molebatsi (PressReader.com - Digital Newspaper & Magazine Subscriptions)).

The Assistant Minister of Trade indicated that out of 4893 liquor outlets in the country, 650 had been forced to close down their business, and one of these was one of the country's largest producers, leading to loss of jobs and loss of income

during the COVID-19 lockdowns and bans on alcohol sales. The submissions made by the Assistant Minister of Trade demonstrate the long-standing argument that the industry contributes immensely to the country's economy as well as creating employment.

The Assistant Minister of Trade's arguments in 2020 for the lifting of the ban resonated with the argument presented by the respondent from the alcohol industry (A1 Alc): the industry contributes immensely to the country's economy. Alcohol industry actors also felt that the lack of inclusion in consultation on the levy indicated that they were not considered a relevant stakeholder to align, engage, and share information and best practices in response to the harmful use of alcohol in the country. The industry exerts a significant influence not only on commercial activities but also on social and political perceptions, as noted by a respondent from the industry (A1 Alc):

> *"One of the things we did as the industry was to campaign against the Alcohol Levy, we were calling it a blunt instrument that maybe we should work together with them. So, we were against the levy, and lobbied against the reduced time and we were also lobbying against traditional beer (Chibuku) regulation because apparently Chibuku is making a lot of money for the traders, and those selling it were being affected by the interventions."*

The alcohol representative (A1 AIC) stressed that they knew from the onset that the levy did not make any meaningful sense to them and that it would have a negative impact on the economy, leading to a reduction in liquor traders' revenues, job losses, as well as business closures. For this respondent (A1 AIC), the complete lack of consultation regarding the introduction of the alcohol levy was a serious concern and demonstrated that the government was not committed to engaging with them as a relevant stakeholder. Furthermore, the alcohol industry respondents held the view that the government was also reckless in their approach because the government was a major shareholder in Sechaba Holdings and upon realizing that it decided to drop the levy from 70% to 55%, and then to 35%, and also decided to settle the matter out of court with the industry.

The respondent from the MoHW Alcohol Division (2MOHAL MOHW) stated that they had been warned by their international partners not to engage with the

alcohol industry, primarily because the industry's major concern is on the volumes of sales and profits from alcohol, which in turn directly undermines people's health. The respondent did not mention who those international partners were. However, it is worth noting that despite the warning by their international partners not to engage with the alcohol industry, which they followed, the study findings show that this was, however, counter-productive because of the backlash and legal actions the government faced from the industry after not involving actors from the industry. The alcohol industry has little interest to act on health issues and will try to water down and prevent restrictive measures which they deem harmful to the industry and yet without them at the table meaningful progress cannot be made; the biggest challenge is now how to check their power and not let them take over and dictate terms to the government.

Respondents who were present when the controversial levy was introduced in 2008 consistently recalled the lack of consultation with the industry. In their view the debate is not *whether* the government should be working with the alcohol industry, but rather *how* they should do so (A1 Alc). This is an important debate because the government and other actors must take action to reduce the harmful use of alcohol and the non-communicable disease burdens it can cause. The CSO representatives and a private sector respondent (The Botswana Motor Vehicle Accident Fund [MVA]) noted the importance of the government, civil society organizations, and public health agencies in working with the alcohol industry to reduce the harms alcohol can cause. Indeed, the government has introduced operating hours and age limits accompanied by various legislative frameworks and policy to curb alcohol abuse in the country. However, the study findings show that the government's actions have been met with lobbying and countermeasures from the alcohol industry leading to legal cases. The interviews with various respondents and reports from the print media show that the alcohol industry's commercial production is accompanied by advertising and promotion, which position the beverages as an aspiration of choice, thus providing a gateway to constant tussles between the government and the industry.

> *"But, yeah, you know, business was not consulted, the community was not consulted. Even the implementing part, the relevant Ministries, were taken by surprise, which is that they had to continue putting specific laws in place that were to address that particular policy. It caused chaos and havoc from*

a business point of view obviously because it was overnight. You know, the liquor industry requires pre-planning for the implementation of any intervention, so it caused a lot of chaos." (A1 Alc).

Academic researchers also criticised the narrow or individualistic approach of the Alcohol Levy, which placed the responsibility and cost burdens on individuals to change their drinking behaviour and promote public health, rather than adopting a more holistic approach and focusing on wider social determinants which contribute to drinking cultures, including the alcohol industry. The exclusion of the alcohol industry in the policymaking process was therefore also noted by academia and researchers. The respondent from the Alcohol Industry (A1 Alc) stated that the relationship between the alcohol industry and the MoHW has not been cordial and pointed out that it was actually better when the levy was still housed at the Ministry of Trade. To the respondent, this was particularly the case because public health actors have consistently viewed them with scepticism, arguing that the involvement of the alcohol industry is driven by profit maximization and fiduciary responsibilities to the industry's shareholders, with little concern for health. As a result, study participants from the alcohol industry stressed that when it was moved to the MoHW, this led to animosity with litigations and counter suits between the government and the industry. The participant stated that the introduction of the alcohol levy not only negatively affected liquor traders, but also led to social ills because accompanying liquor trading hours restrictions caused people to resort to binge drinking. (A1 AIC) stated that:

"The limitation of the levy as it was, that it was not successful, is that you saw a number of consequences that led to problems, I mean, not talking just on the business side, but even, you know, those things which were trying to be avoided. Thus, binge drinking has become the norm. Society had never really had that, but as a result of having shorter access periods, people consumed a lot of alcohol in a short period of time. We saw also a sharp rise in unlicensed, home brews so after we close the liquor outlets, the people went to those places that were also potentially quite dangerous."

Overall, then, the introduction of the Alcohol Levy was done without consultation with the stakeholders from the alcohol industry, and even the people of Botswana. It was just spontaneous and later received a serious backlash, and was highly

criticised by the industry, print media and members of parliament in the country. While the introduction of the levy and the policy were meant to address the harmful use of alcohol, it had unintended consequences which led to the rise in binge drinking and an increase in Gender Based Violence (GBV), (28). Compounding the problems associated with the levy, the tax levy revenue was misused and used for unintended purposes with some CSOs such as BOSASNET receiving a minimal share to respond to alcohol and substance abuse, and as such promises made to construct rehabilitation centres have become rhetorical statements.

6.5.3 The use of Corporate Social Responsibility

The use of Corporate Social Responsibility (CSR) by the alcohol industry can be interpreted as an approach to show that they can be responsible to some degree and should therefore be seen as legitimate actors in the NCD response. It is, however, important to note that CSR has been in place and used by the industry long before the introduction of the levy. The alcohol industry respondents noted that the industry uses a variety of activities to address the nexus between the harmful use of alcohol and public health problems, including corporate social responsibility programmes that work independently from the government. The respondents from the alcohol industry regarded the industry's CSR initiatives in the country as part of their mandate to give back to the community. The CSR initiatives are guided by five key components, as shown in Table 4: alcohol information and education provision, drink driving prevention, supporting community and social organizations, research involvement, and policy involvement. The study findings show that the industry also has a graduate development programme named Kickstart that sponsors undergraduate leadership and entrepreneurial programmes. Kickstart, according to the alcohol industry respondent and KBL website, is an entrepreneur development programme for people aged between 18 and 30, providing mentorship and training to young entrepreneurs. The industry also supports national sports initiatives.

Table 4: The five main types of CSR initiatives undertaken by alcohol industry actors.

Types of CSR initiatives	Description / relevance to NCD policy	Implementation method
Alcohol information and education provision.	Provision of education and information, on issues such as personal and/or parental responsibility, moderation, under-age drinking, and the health effects of drinking alcohol.	Mass media: national television (BTV) and radio commercials (public and private). Newspapers (public and private). Billboards, on premise (bars and taverns). Web-based sources: websites (KBL & BAIA), social media and online advertisements. Merchandising material. School, through the DREAMS project and working with youth movement groups. Interventions in bars/taverns: workshops and educational interventions.
Drink driving prevention.	Interventions for drink driving prevention including information and education.	Breathalyzer and booze bus to Botswana Police Services. Mass media: television and radio commercials. Labels, banners. Merchandising material. Sobriety checkpoints working alongside the Botswana Police and MVA done especially during the public holidays. Blood alcohol concentration tests for young drivers.
Supporting community and social activities and organizations.	Development and funding of social activity organizations working on alcohol awareness.	Working with grassroots organizations, associations, charity organizations, sponsoring their events, family fun days. Support to sports associations engaged in promoting healthy living through e.g., marathons and golf days. Support to charities that are active in alcohol policy, or that have board members from the alcohol industry (which are active in alcohol policy).
Policy involvement.	Activities designed to influence policy making.	Participation in high-level policy meetings of the MoHW and other stakeholders. Dissemination of publications at government consultations. Publication and dissemination of policy documents: reviews of alcohol policy issues, charters, working papers, guides to policy implementation and policy tool kits.
Research involvement.	Support of research/researchers and dissemination of research findings on alcohol and health issues	Support for grant making organizations. Funding researchers and supporting research centres. Publication and dissemination of scientific documents: essays, monographs, reports, briefing papers, peer-reviewed journal articles, Graduate development programmes.

6.6 Conclusion: Policy Community Cohesion and the Necessary Role of Civil Society and Non-Government Actors to Promote Coherent NCD Responses

Policy community cohesion is defined as the degree of unity between various actors involved in an issue, (27). The response to HIV/AIDS in Botswana was notable for its cohesion and involvement of various stakeholders, with substantial funding and political commitment (112). The development of a national strategic framework for NCDs and their risk factors, led by the MoHW, appeared to signal a similar level of cohesion and commitment to the NCD response. However, the study findings have revealed that, in contrast to the HIV response, there is a lack of cohesion within the policy community, with little connection between key stakeholders and fragmented, inconsistent participation of different stakeholders in the NCD response who sometimes have competing interests. In this concluding section I consider what the findings of this chapter show, overall, in terms of how cohesive or fragmented the policy community is and what this could mean for the future of the NCD response in Botswana. Table 5 provides a summary of the key non-government actors who have a stake in the NCD response in Botswana, showing the difference between their mandated roles and their roles in practice (as revealed in the interviews).

Table 5: Actors and their specific roles

Organisation type	Mandated Roles	Roles in Practice	Source / Interviews & documents
Civil Society Organizations (CSOs) & Community Based Organizations (CBOs). (Donor-funded and home-grown)	• Participating in implementation of national efforts, in particular individual and community-based interventions including hard to reach and vulnerable areas and groups. • Provide an important source of information for both citizens and government. They monitor government policies and actions and hold government accountable. • They engage in advocacy and offer alternative policies for government, the private sector, and other institutions. • Analyse the situation, formulate recommendations, develop policy options, and engage in policy dialogue to address conflicts.	• Ineffective in the response to NCDs. • Focuses on the response to HIV/AIDS and little on NCDs. • No budget, dependent on donor funding. • Work in silos and some of them develop their own tools and guidelines to assist high-risk population groups. • Some of them did not participate in the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs. As a result some organizations felt this was a selective and biased approach by the MoHW, which had preferences for whom to work with from the CSOs. • Poorly resourced and one of the CBOs entangled with corporate governance issues over the control of the organization. • Over dependency on donors with few home-grown initiatives; as a result the donors set the agenda and control how their funding has to be utilized. • Lack of effective l leadership. Constrained on assisting high-risk population groups as there are no national policy guidelines to assist this community. • Donor support on HIV/AIDS has also dwindled.	**Interviews** Group Interview: 3 senior officials from BOCAIP (C1 BCP). Group Interview: 2 senior officials from BONELA (C1 BON). Group Interview: 2 senior officials from BOSASNET (C1 BOSAS). **Reports** **Websites** Websites, portals and reports.

		• Limited funding on NCDs from home-grown sources. Only limited funding from NAHPA to some NGOs and CBOs which is equally not sufficient.	
Professional Associations. Botswana Medical Association. Business Botswana.	• Botswana Medical Association is a non-registered body of physicians and non-physicians. • Business Botswana (Business forum) – Health sector forum. Focuses on private sector health services delivery and health systems strengthening.	• Discusses private health sector participation and health services delivery.	**Reports** **Websites** Business Botswana web portal.
Youth Council	• Advocacy – Mostly on HIV/AIDS • Voice of the youth, on many developmental and health issues but not on NCDs. • Policy making – Often gets consulted as a relevant stakeholder but were not consulted in the development of the National Strategic Framework on NCDs. • Lobbying: Government and other stakeholders to listen to the voice of the youth. • Volunteerism: Different programmes; DREAMS project; Youth and substance abuse.	• They serve as the voice of the youth. • Perceptions and beliefs in the framing of NCDs. They see them as the disease of the elderly. • Used to be an NGO and after there was maladministration at the Council, a deliberate decision was made to make it a department under the Ministry of Youth, Gender, Sports and Culture. • It is now dependent on the parent Ministry where they are housed. • Active in HIV/AIDS awareness campaigns, including the DREAMS project to reduce HIV/AIDS in Adolescent Girls and Young Women.	**Interviews** Youth representative, **Reports** **Website**
Private Sector providers. Botswana	• Providing funding and identifying funding opportunities to support national efforts.	• Profit maximization is their primary objective. • Feel isolated by the MoHW and NAHPA as a relevant stakeholder.	**Interviews** Medical Insurance interviewees.

Medical Aid Society.	• Providing technical support for implementation and addressing gaps in implementation • Developing the minimum package of wellness services for employees. • Private-for-profit sector specifically has situated itself as a driver of innovation and provider of high-quality healthcare, contributing to the provision of health-related services and products, funding and workforce training, and infrastructure support. • Medical Insurance member subscriptions. • Member of Business Botswana which engages with the government.	• No coordinated efforts and means to work with the government. • Feels they are isolated by the government because of a competitive mindset by the government. They are not seen as a relevant stakeholder but rather seen as a competitor. • UNGASS 2011 Political Declaration, and the WHO "Best Buys", place emphasis on the need for the private sector to be meaningfully engaged in the response to NCDs and risk factors. • Medical insurance cover for members not sufficient to assist patients with NCDs. • There are instances where the private sector has not operated in the public interest. • Conflict of interest between public health good and business interest.	(P1 BOMAI), Official from Botswana Medical Aid Society. (P1 MR), Official from Med Rescue International. (Made numerous attempts to interview Business Botswana but however, failed).
Pharmaceutical Association and industry	• A professional body of pharmaceutical practitioners (pharmacists). • Carry out awareness campaigns on NCDs outside the ones provided by the government.	• Although they do not have funding to carry out awareness campaigns on NCDS once a year in the country. • Also work closely with the Botswana Medical Association, a non-registered entity comprising pharmacists and physicians in the country; engage in discussions on healthcare service delivery including NCDs in the country.	**Interviews** (P1 Pha) **Websites** Pharmaceutical Association. Websites
International Agencies, Foreign Research Groups and Donors	• Research and support. • Technical Assistance in the development of the Botswana Multisectoral Strategy for the Prevention and Control of Non-Communicable Diseases. • Partnerships: Botswana Harvard Partnership and its involvement in	• Limited research and support for NCDS compared to the case in the response to HIV/AIDS. • Assisted in the development of the Botswana Multi-sectoral Committee in the development of the National Strategic Framework on NCDs. Their role limited to only professional assistance and not funding.	**Interviews** **Reports**.

	HIV/AIDS research in Botswana, training and development. • Partnerships: Rutgers University: Signed joint MoU with the Botswana government on a number of key thematic areas. Training and development. Oncology Nurses. • JPIEGO: Johns Hopkins also involved in research and have programmes on Cervical Cancer.	• Donor flight, because the country is regarded to be in the high upper-income group, as noted in Chapter 1. • Limited resources and partnerships creating animosity in terms of reporting lines and seniority and remuneration packages which are highly attractive.	
Alcohol Industry & Profit Orientated private sector service providers	• Lobbying. • Corporate Social Responsibility (see Table 6.1). • Regulatory framework and adherence to the set liquor regulations. • To address issues related to the harmful use of alcohol.	• Non-responsive on NCDs. • Focused on profit-making. • Self-serving agenda on health interventions. • Resistant to the Alcohol Levy and even labeled it as "Jihad" and "government war on fun". • Their role is focused on the business aspects of liquor and not on the health side. • No cordial relationship with MoHW. • Not consulted when the National Strategic Framework on NCDs was developed. • Their participation is mainly on Corporate Social Responsibility (CSR) and marketing	**Interviews** Botswana Alcohol Association. **Websites & Reports** Alcohol Division of the MoHW Business Botswana website. Newspaper articles:

This chapter has shown a wide variety of responses and perspectives among the non-government actors who have had a stake in the NCD response. Many have felt excluded from the policy development process and therefore feel disenfranchised in the implementation stage.

In the HIV/AIDS response, civil society, youth voices and, later, professional associations, all played a critical role in developing a widespread, coherent and highly successful response in Botswana. The picture is very different for NCDs. Civil society participants expressed their frustration over their lack of recognition and involvement by government as well as the lack of resources (from both government and donors) which impeded their capacity to respond either through advocacy, awareness raising and campaigning or in service delivery. Their over-dependence on donor funding has created a dependency syndrome which leads them to follow the priorities set by the donors, which remain more focused on HIV/AIDS than on NCDs. Furthermore, and partly due to the lack of resources, the CSOs seemed to lack effective and efficient coordination and collaboration mechanisms between themselves or other actors with whom they could have collaborated. Some have been mired in corruption scandals and are either in court cases or have been dis-established (like the NGO that preceded the Youth Council); others are fighting to gain superiority over others instead of joining forces. Donors for their part confirmed the lack of real priority they allocate to NCDs. These factors have all led to a fragmented CSO landscape and constrain CSOs' effective response to NCDs.

Other important civil society voices, the professional associations and the youth, have also failed to provide cohesion in their action. The Youth Council feels that NCDs are not a priority issue for young people; the professional associations feel they have been marginalised and do not seem to have been able to negotiate a space at the decision-making table. In any case, as Chapter 5 illustrated, there has been a lack of leadership by the MoHW under whom the NCD response has been fragmented; there are no national guidelines on implementation; and there are unclear – and unfunded – roles and expectations at the decentralised level of implementation.

In this context, civil society organisations and professional associations focused on particular NCDs (diabetes, particular cancers) have reverted to a siloed approach,

developing their own programmes and guidelines in isolation. In the case of cancer care, the role played by Rutgers University has undoubtedly been significant. They supported the development of four specialist centres to help advance the national programme in cancer care, created joint research and training programmes to improve cancer care and prevention, created local, sub-specialty medical and health professionals, and expanded national health care capacity in this area. However, they have not been active in trying to join up the various elements required for a coherent NCD policy, choosing instead to promote their own specialisation of cancer care. Ultimately the lack of cohesion across the many NCD players has led to a plethora of guidelines for specific NCDs and leaves important actors disconnected from each other; this then further exacerbates and fragments the national response.

The private-for-profit sector – medical insurance companies, pharmaceutical companies and many private sector healthcare providers – also feel they have been excluded by government. Furthermore, they are driven by profit motives which means they have little incentive to be involved in NCDs and therefore have not pushed to be part of the decision-making processes. For Insurance companies, expensive NCD treatments do not generate much profit and are not included in their medical insurance schemes (because members do not pay enough); therefore the insurance companies have little motivation to get involved in NCD prevention activities either.

The pharmaceutical association is a group of pharmaceutical professionals whose main interest is to educate and carry out awareness campaigns on NCDs and risk factors outside the ones taken by government and civil society organisations. They also assess the availability and non-availability of medical supplies in the country and cross check against corruption in the medical supplies. However, although this forms part of their area of interest, they have minimal influence to push the agenda to be able to influence the medical stock-outs and shortages within health systems delivery.

Nowhere is the tension between the profit motive and public health interests clearer that in the clash between the alcohol industry and the government. While the Ministry of Trade saw the alcohol industry as a partner, involving them in the initial discussions on the levy, when responsibility for the alcohol levy moved to the MoHW, this Ministry understandably thought that there would be a conflict of interest to involve an

industry whose motives (to sell more alcohol) were in direct contradiction to their own efforts to reduce alcohol consumption. The industry representatives were therefore excluded, but this led to counter processes which undermined some of the alcohol regulations. Feeling excluded, the alcohol industry launched a legal attack, threatening litigation. Although the Ministry countered this with its own legal threats, the industry lobbied heavily for a significant reduction in the levy charges, which they eventually won. Their success was probably aided by the unintended consequences of the levy, which led to a rise in binge drinking and an increase in GBV cases, (28) but also the tax levy revenue was misused or used for unintended purposes, with some civil society organizations receiving only a minimal share to respond to alcohol and substance abuse. The industry was also able to garner popular support as popular views changed when the former President (who strongly promoted action against the harmful use of alcohol) was replaced. The former President was accused of having failed to consult and he was feared because of his authoritarian style of leadership leading to the labelling of the introduction of the levy in the country as "Government's war on fun", with print media joining in to define it as "Jihad". To improve their public image the industry has also promoted its action in Corporate Social Responsibility (CSR) but these do not address the impact of alcohol on health.

Clearly there are many interests at play in the NCD field and the narrow interests of specialist disease-focused groups and projects compete with industry's profit motives and the Ministry's well-grounded but ineffective efforts to prevent the risk factors for NCDs as well as improve the treatment response. Groups that have been influential in other health issues – CSOs and youth – are marginalised from the current debate, hampered by lack of finances and resources (CSOs) and lack of motivation (youth). Overall, there is a stark lack of coherence in the Botswana NCD policy field, in striking contrast to the coherence around the HIV/AIDS response. Unless alliances can be forged among the non-government actors working to prevent NCDs, and these organizations can work alongside government actors, and unless the shortages of drugs and access to treatment can be addressed, it seems likely that the NCD response in Botswana will continue to be fragmented and incoherent.

Chapter 7: Discussion

This thesis has sought to assess and analyse the policy responses to NCDs and their related risk factors in Botswana, and the adequacy of these policy responses, in view of the growing NCD burden in the country. First, it sought to analyse the actors, contexts, and policy development processes underpinning the response to non-communicable diseases (NCDs) in Botswana, and the thesis examines the factors that have supported or obstructed this response. Second, the PhD aimed to understand whether Botswana has leveraged (or not) learning and corresponding policy structures from the HIV policy development response, in relation to the NCD response. The overall overarching rationale for the thesis is, therefore, to provide in-depth policy analysis of the NCD control strategies in the country, in order to support more effective policy development and contribute to policy and practice change.

This concluding chapter provides a brief overview of the findings and discusses key cross-cutting themes spanning Chapters 4, 5 and 6, and their implications for policy and practice. The themes are poor implementation of existing NCD policies (document review analysis), and six themes explaining the poor implementation, distilled from the stakeholder interviews:

- actor fragmentation and lack of engagement
- fragmented institutional structures
- lack of coherence between NCD policies
- Division in political leadership and a lack of champions for NCDs
- the alcohol industry and its dual role
- donor funding and flight.

This chapter also provides a reflection on Shiffman and Smith's framework and its usefulness for my thesis, and concludes with an overview of the study contributions to knowledge, limitations and recommendations.

7.1 Document Review and Analysis: Overarching Policy Exists but Progress on Implementation is Poor

The thesis analysed the policy documents, official and grey literature reports and newspaper articles relevant to the country's response to NCDs and risk factors. Document analysis was undertaken to gain a greater understanding of the breadth and depth of the country's response to NCDs, and of the actual steps in the policy process leading to the development of the NCD strategy in the country. Each document, report and newspaper article was reviewed for specific or general policy statements, i.e., stated goals, objectives, or implementation plans, related to the response to NCDs.

Document review analysis indicates that the UNGASS Political Declaration 2011 and the WHO "Best Buys" 2013-2020 played a significant role in stimulating and leading the Government of Botswana to adopt the framework and stated guidelines in the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs, as well as the inclusion of NCDs for the first time in the country's National Development Plan (#11) and 2019 national budget. Despite the concerted efforts by the government to develop the Botswana Multisectoral Strategy for the Prevention and Control of NCDs, the implementation of this strategy has faced numerous challenges, with the WHO Progress Report 2022 reporting that the country is still lacking in its response to NCDs. Some of the reasons indicated in the WHO Progress Report were insufficient budget allocation for NCDs at national level as well as a lack of trained human capital to be able to deal with the response to NCDs. Document review also indicates that despite measures to better regulate alcohol sale and use, the industry's main interest lies with profit maximisation and it has resisted attempts by government and civil society to better regulate alcohol sales and purchases. These tensions were examined in Chapter 6.

The Botswana NCD Strategy is supposed to catalyse a multi-sectoral response in tandem with health systems strengthening, particularly at the PHC level, but this has not materialized, as discussed in Chapter 5. The objectives of the Botswana NCD Strategy 2018-2023 have not been adequately implemented and analysis in Chapters

5 and 6 indicates that unlike in the response to HIV/AIDS, there has been no policy champions to spearhead a robust response to NCDs, and there has been little investment by the country in PHC to enable it to effectively respond to NCDs. Furthermore, the Botswana NCD Strategy and the relevant policies developed towards the provision of health services delivery are not linked, therefore there is no supporting budget for NCDs, and a lack of human resources trained to diagnose and manage complex NCDs effectively. There is little apparent prioritization of NCDs in research funding, and there are high levels of stock-outs for NCD medicines, especially for diabetes and high blood pressure.

Overall, the thesis document review reveals that despite political will to develop an overarching NCD strategy, there is a lack of implementation action on NCDs, especially the health promotion aspects at sub-national level. At that level there is confusion over roles and responsibilities when implementing NCD service delivery and control. There is also a lack of coherence between national and sub-national level structures and policies. Moreover, there is a lack of trained human resources to implement policies to respond to NCDs in the country, including a deficiency of physicians and trained nurses specialising in complex NCDs both at the national and sub-national levels, including, for example, oncologists and oncologist nurses.

7.2 Explaining Poor Implementation: Stakeholder Insights

The semi-structured interviews revealed a range of explanations for why the progress reports continue to show deficiencies in the NCD response. These particularly relate to fragmentation of actors and structures – overall the roles and responsibilities at different levels of the health system and other actors remain unclear and there is no strong champion for NCDs who could spearhead a more coherent commitment to action. The six key themes are discussed in turn below.

7.2.1 Actor fragmentation and lack of engagement

This thesis discussed the relationships between the actors (government and non-government actors) at the national and sub-national levels, and illustrated how they work together or not in relation to NCD response in Botswana. I have described the division of responsibilities, the findings on the coordination and connections or

disconnections between the actors. Table 3 in Chapter 5 summarized the discrepancies between the actors' mandated roles and responsibilities and the realities revealed through the interviews. Sub-national actor responses are critical to understanding how policies are operationalized and underpin service delivery at this level and shape their development, and these actor responses were considered in the analysis.

The thesis has established that NCD response responsibilities have been fragmented through their division into curative and preventive roles, with the former being the primary responsibility of the Ministry of Health and Wellness (MoHW) and the latter the responsibility of the reconfigured National AIDS and Health Promotion Agency (NAHPA). My analysis revealed that both these institutions have faced challenges in implementing their mandated responsibilities. Findings show that although the country developed the Botswana Multisectoral Strategy for the Prevention and Control of NCDs, the strategy was not designed well to respond to NCDs because there is insufficient budget, unlike the case with the response to HIV/AIDS. Respondents in Chapters 5 and 6 noted that while there is government intent to respond to NCDs, this is not supported by funding, and moreover, there is no international donor funding for NCDs, as was the case with HIV/AIDS, where the country received generous support from the Bill and Melinda Gates Foundation, the Merck drug company, and through the public-private partnership with ACHAP, leading to the country being the first in Africa to provide free Anti-Retroviral Therapy (ART) to its citizens.

The thesis has also shown that key actors, both government and non-government actors, are faced with a host of challenges causing fragmentation and lack of engagement in the response to NCDs. My study and others show that the sub-Saharan region faces unique challenges in combating NCDs, including lack of funding, lack of availability of studies and guidelines specific to the population for diabetes patients, lack of availability of medicines, differences in urban and rural patients, and inequity between public and private sector health care (113). Despite the rising burdens of diabetes and other NCDS in LMICs, external and internal funding for health care needs continues to focus on communicable diseases while neglecting the

needs of the growing populations experiencing excess morbidity and mortality from NCDs (113).

Figure 1 in Chapter 5 shows a stakeholder mapping of the main actors and their relationships as specified in the policy documents. Figure 1 demonstrates that the NCD response in Botswana is led by the MoHW (curative aspects) and by NAHPA (promotive and preventive aspects), while the policy implementation and progress with the response to NCDs and risk factors is the responsibility of a high-level steering committee which is comprised of Permanent Secretaries and Executives and is chaired by the Vice-President housed at the Ministry of State President. NAHPA also serves as the secretariat of the National NCD Coordinating Committee (NCCC).

The thesis established that MoHW in its response to NCDs as the steward has been met with a host of challenges including weak leadership and governance, as well as lack of coordination among stakeholders and failure to repurpose the structures used in the HIV/AIDS response. All these in turn lead and contribute to lack of engagement by other actors in the response to NCDs and a failure by the steward to properly coordinate and share information or decision-making with the relevant stakeholders. The thesis has also established that despite efforts to integrate NCDs into the national policy agenda, and its resulting structures such as the establishment of NAHPA, little progress has been made in building multi-sectoral collaboration or implementing decentralized NCDs services. The thesis has demonstrated that in order to mitigate actors' lack of engagement with the MoHW, creating accountability for action has been identified as an additional way to strengthen the MoHW's stewardship.

Furthermore, private sector actors (medical insurance and alcohol industry) have also felt excluded from policy development processes. Reports and the WHO "Best Buys" and the UN Political Declaration, however, emphasize the need to include such actors in the policy development process. This argument was equally made by Beaglehole et al where they emphasized the need to include sectors such as the media, agriculture, private health facilities and food industries (114). Other authors equally stressed that the involvement of non-state actors is crucial in evidence generation (115), (116). Bosu stressed that the involvement of non-state actors can lead to increasing awareness, whereas Al-Bahlani and Mabry indicated their involvement

leads to improve the implementation of regulatory frameworks (22, 117). Informants in this study also added that public private partnerships should also be strengthened as the impacts of NCDs are cross-cutting.

The thesis has established that the MOHW and NAHPA have an unclear demarcation of responsibilities leading to confusion and often competition over roles and which actor is better suited for that role, partly because NAHPA now reports directly to the Office of the President and no longer reports to the MoHW as it did previously. Whilst the MoHW wants to assume superiority and wants to be an overall leader, NAHPA on the other hand does not see that it has any allegiance to the MoHW. This situation of tensions between government actors is not unique to Botswana. Studies in other low- and middle-income settings have similarly noted diminished roles of local policy actors in the policy process, particularly when they lack sufficient control of financial and technical resources (118), (119) and (120).

My analysis has shown how the power struggles between the MoHW and NAHPA have further exacerbated the fragmentation of the national response to NCDs. This fragmentation is mirrored at the district level where the Ministry of Local Government and Rural Development has not managed to repurpose the decentralised structures that were so successful in the HIV/AIDS response. So, while decentralization of health services has led to greater responsiveness and adaptation to local needs, preferences, and capacities in the response to HIV/AIDS, this has not been the case with the response to NCDs.

Unlike the response to HIV, leadership and coordination across sectors and actors have not been effective because of fragmentation and power struggles, which impede the ability of different agencies and levels to work together in a combined manner. Although there is a dedicated NCD Prevention and Control Unit with staff at the NAHPA, respondents commented on the high degree of structural variation at national and sub-national levels, coupled with the shortage of trained manpower at NAHPA, which led to the transfer of two staff members from the MoHW NCD Unit to NAHPA, in order to establish the NAHPA NCD Unit and other structures. A further part of their mandate is to make sure there is an effective collaboration between NAHPA and the Ministry of Local Government and Rural Development, as well as with the

MoHW which has direct links with DHMTs, which are responsible for PHC. However, the study findings indicate that there is poor coordination, haphazard responses, poor and ineffective leadership, lack of transparency by NAHPA, and preferential treatment given to some civil society organizations. All these factors have contributed to the failure to implement NCD policy, both curative and preventive.

7.2.2 Fragmented institutional structures

Studies show that an increasing number of countries have established special units or departments specifically for NCDs, giving a clear institutional identity to control and prevention of NCDs within Ministries of Health, (121). However, different studies have shown that the organizational structure, remit and influence of NCD units within Ministries of Health varies across countries (121, 122). In the SEA region for instance, all countries have adopted a multi-sectoral action plan to address NCDs, (122). In keeping with the plans, most countries have established a national NCD governance body for strengthening multi-sectoral coordination. Health ministers chair the governance bodies in seven out of the 11 states of the SEA Region, demonstrating the region's increasing recognition of the importance of political leadership in NCD governance, (122).

Research suggests that the relationships and division of roles and responsibilities between NCD units and other sector-wide institutional structures, such as policy and planning units and health information units, are often not clearly specified. In some countries, the structures involved in NCD control seem to function mainly as technical units and not as specific programme management and implementation entities (121). Furthermore, a global key informant survey showed that in many low-and middle-income countries (LMICs) particular functions related to NCD control are spread across other major organizational structures such as those leading health promotion and nutrition activities, and these are often distinct entities under different leadership (121) (122). In that sense the functions and responsibilities often overlap, as NCD units also reported health promotion as their key responsibility (121). This thesis has established that the common goals and targets articulated in sector-wide and NCD-specific policies and plans can, in theory, be pursued effectively and efficiently. For instance, the country has NAHPA as the national coordinating team responsible for

the overall development, monitoring and coordination of policies, mechanisms and guidelines for the health sector. However, its role in coordinating NCD policies across the MoHW areas of responsibility is not known.

In the case of Botswana, this thesis has shown that the MoHW NCD Unit's remit and activities are intersecting with the MoHW and NAPHPA at the national level, and the DHMTs at the sub-national level. The thesis found that the roles and responsibilities of the NCD Unit at the MoHW primarily relate to curative health care whilst NAHPA is responsible for health promotion and awareness. The implication is that the Officer-in-Charge at NAHPA coordinates the implementation of NCD programmes through specific implementation agencies such as civil society organisations. The Ministry of Local Government and Rural Development engages formally and informally with the sub-national level structures. The sub-national level DHMTs are responsible for curative aspects while health promotion relating to NCDs is the prerogative of District Multisectoral AIDS Committees (DMSACs) and Village Multisectoral AIDS Committees (VMSACs), administered through the District AIDS Committee (DAC). However, study findings indicate that finances and efforts are still focused on HIV/AIDS, not NCDs, as confirmed by the study respondents at the sub-national level. The study found unequal engagement of civil society organisations in policy development for NCDs. Thus, respondents from NGOs with relevant activities and an interest to be involved in NCD policy development reported that they were not consulted nor were they included as part of the TWGs during the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs.

The literature indicates that NCD-specific structures are justified to build much needed technical capacity as well as to provide institutional identity and visibility, especially when similar structures exist within a Ministry of Health for other public health problems perceived to be important, (123) and (122). According to (123), however, it is critical that these NCD-specific units are developed only as technical advisory bodies with strengthening of their capacity to analyse up-to-date technical information, develop clinical guidelines, and advise on the suitability of different proposed interventions, and to do research. In addition, (123) and (122) noted that NCD-specific units should focus on strategizing, guiding, and coordinating policies and

activities across different stakeholders within and beyond Ministries of Health. However, these units should not act as direct implementing bodies for NCD plans and management and delivery of NCD-related services, which should rather be left to sector-wide organizational structures. In the context of Botswana, the NCDs units' structures are fragmented and not playing same role yet focused on NCDs. For instance, at national level this thesis has demonstrated that there is an NCD Unit at the MoHW responsible for curative aspects and an NCD Unit at NAHPA responsible for preventive care; at sub-national level, DHMTS are responsible for curative care while and the DMSACs are focused on health promotion through District AIDS Coordinators (DAC).

The findings of this study indicate that gaps in Botswana's NCD Strategy include amongst other things weak intersectoral collaboration, inadequate contextualization of the guidelines, fragmented leadership and political leadership ineptness, inadequate commitment of the government and haphazard responses and programming, limited financial resources at the national level and no budget for NCDs at the sub-national level. There are also clear indications of an unprepared health system with no trained human resources for NCDs, especially at the sub-national level. Heavy reliance on the data collected at DHMT facilities and sent to the MoHW every six months may also be a weak feature of information systems.

7.2.3 Lack of coherence between NCD policies for different NCDs

The document review also suggests that although national policy developed an integrated approach to addressing NCDs and risk factors, as stressed in the Botswana NCD Strategy 2018, there remain some gaps and challenges as the country's response to health issues remains predominantly focused on HIV/AIDS, as discussed in Chapters 5 and 6. A further problem might be that the NCD strategy responses, although considered the 'standard' model, are however still modest given the scale of the challenge, as argued in studies conducted by (124) and (125). According to these authors, standard NCD responses will be insufficient to respond to the global forces driving NCD epidemics, in particular the tobacco, alcohol and food industries, they are also limited to four main NCDs, and they pay insufficient attention to other risk factors, such as air pollution, and the need to strengthen health systems. As a result, (124)

provided seven key issues and a more comprehensive approach to be considered in the response to NCDs.

The thesis has established that with regards to the harmful use of alcohol and tobacco, these behaviours are sought to be addressed by the Alcohol Policy and Alcohol Levy, and the Tobacco Control Act 2021 (which replaced the Control of Smoking Act). Although there are considerable gaps and the country has received a backlash from industry for its policy and regulations on the harmful use of alcohol and tobacco use, the country is considered to be making good progress in the response to the harmful use of alcohol and tobacco, in line with the WHO Framework Convention on Tobacco Control and the three Dimensions on Harmful Use of Alcohol. There is also a lack of coherence between national and sub-national level structures and policies. Despite these important policies, however, as noted earlier there remains a lack of trained human resources to respond to NCDs in the country, including a deficiency of physicians and trained nurses specialising in complex NCDs, both at national and sub-national levels.

In 1978, the Alma-Ata declaration endorsed primary health care (PHC) as the "cornerstone" in health systems, (126). The 2018 Astana Global Conference on PHC further declared PHC system strengthening as the most inclusive, effective and efficient approach to achieve health for all, (127). PHC is acknowledged globally as the foundation of developing a robust health system response for NCD prevention and control, (128).

The thesis did identify some encouraging and more positive response trends, with the establishment of more integrated NCD services as witnessed with the revitalization of PHC in 2010 and the establishment of District Health Management Teams (DHMT). Common risk factors for major NCDs (e.g., tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol) warrant an integrated multidisciplinary approach to disease prevention and management. The study findings show that the transformation of the National AIDS and Health Promotion Agency (NAHPA) from the National AIDS Coordinating Committee (NACA) in 2019 was done to pave the way for an integrated approach within the country's health system to NCD prevention and treatment alongside HIV/AIDS and other infectious diseases. According to the study

findings, NAHPA has set up an NCD Unit to revitalise the NCD response regarding prevention, and the MoHW has an NCD Unit responsible for curative aspect of NCDs. The study findings also indicate that this integration is also spelled out in the country's NCD strategy and illustrates how it will be carried out at the sub-national level through DHMT and District Multisectoral AIDS Committees (DMSACs). However, this thesis has also established that these structures have been unable to implement policies effectively, because of a lack of coherent leadership with no policy champions either inside government (because of fragmented leadership as discussed below) or outside government (an absence of civil society activists) championing NCDs. This has left a leadership and implementation void, unlike the case of the HIV/AIDS response in the country, where the response to HIV/AIDS was backed by civic activists like David Ngele, the first Motswana to go public about his HIV Positive status and Dipuo Bogatsu who went public with her HIV status in 1993.

7.2.4 Fragmentation in political leadership and a lack of champions for NCDs

(2), established that the global leadership on NCDs has focused predominantly on generating a suite of normative instruments for influencing national policy, together with global targets and reporting processes but with inadequate development assistance for NCDs, or investment in capacity building. This has a result created a vacuum according to the study findings an lack of policy champions for NCDs. Policy champions are recognised as important for driving organisational change in healthcare quality improvement initiatives, (129). Policy champions, or policy entrepreneurs have confidence in a particular policy solution and put time, energy and reputation into implementation, (35). They may occupy positions in governmental or non-governmental organisations, such as interest groups or research organisations, but are also found within healthcare organisations where they are also referred to as clinical champions, (130). They can serve as voices advocating for the implementation of policies that seek to address gaps within the healthcare system and raise awareness of human rights issues, (131). For example, the re-appointment in 2018 of philanthropist and former New York City Mayor Michael Bloomberg as WHO Global Ambassador for Noncommunicable Diseases highlights the importance of global advocacy by champions in civil society, (2). Because of this the appointment of

regional and country rapporteurs on NCDs could also help to motivate and strengthen civil society movements, challenge business and influence governments.

In Botswana, political will was exhibited in the development of the Botswana Multisectoral Strategy for the Prevention and Control of NCDs 2018-2023, as well as its launch. This Botswana NCD Strategy, according to the study findings, was enabled by the policy window set by the UN Political Declaration on NCDs in 2011 and the WHO Global Action Plans 2013-2020. While (132) have argued that some countries have had a lack of stakeholder participation in NCD policy development processes, in the case of Botswana participation was uneven, with the private sector and some civil society actors stressing that they were not invited to participate in the development of the NCD Strategy, whilst others CBOs stated that they were consulted and participated in the steering committee and technical working group. Magnusson R et al, (2021), (2) argued that forms of political persuasion extend beyond the accountability mechanisms adopted by multilateral forums to include direct advocacy by civil society organisations, including through the media. For instance,(133), it is stated that the NCD Alliance, which provides a unifying voice for 2,000 civil society organizations across 170 countries, has issued an advocacy agenda calling for urgent reform to enable participation by people living with NCDs in programme development, implementation, policy-making, and accountability processes at national and global levels. One lesson from the global response to HIV is the strategic value of integrating civil society organisations into the global reporting process, (2). For example, UNAIDS encourages the involvement of civil society organisations in the Global AIDS Response Reporting process, which has continued to evolve since the 2001 UN General Assembly Political Declaration on HIV and AIDS (UN General Assembly,(2).

With regard to stakeholder engagement, the study findings show that the process of the NCD Strategy development took the form of a consultative forum, in which key players in the health sector developed the draft of the NCD Strategic Plan to ensure that the resulting document was comprehensive, led and guided by a consultant with the WHO country office providing technical expertise. This consultative process was affirmed by the MoHW respondents. Similarly studies elsewhere have stressed the importance of such key implementing partners' support in policy development (134).

(135) stressed that an inclusive policy development process contributes to quick adoption and implementation of policies. According to (136) and (137), political actors should not be allowed to dominate the policy development process because this might result in the neglect of areas that might be against the politicians' main interests or aims. Political will and support as reported in this study is, however, necessary, as its absence might lead to policy implementation inaction.

This thesis has demonstrated that a stronger response by government to NCDs is a priority, given the epidemiological transition within the country that is impacting the country's health system, with growing NCD disease burdens. NCDs must not be made to compete against other health priorities like HIV. Atun et al. advise that a unified strategy is required in addressing NCDs (135), and Santos et al. argue that it is necessary to have champions and advocacy groups with strong voices to protect the policy process from hindering influences; other studies have shown such champions to be beneficial (138). In Botswana, the thesis has shown that such NCD response champions are still needed.

7.2.5 The alcohol industry and its contradictory roles: participation for resistance

Table 5 in Chapter 6 illustrates the five components of corporate social responsibility (CSR) adopted by the alcohol industry in the country, and their relevance in addressing the harmful use of alcohol and how it intersects with NCDS. Other studies discuss the relevance and effectiveness of such CSR components. For instance, (139) suggests that education campaigns have limitations, and typically emphasize legal-age drinking, responsible drinking, and the dangers alcohol poses to one's health. Research has shown that heavy drinking over a long period can increase the risk of various health conditions. (140) and (141) add that campaigns and messages do not always have desired results due to various factors, including the cluttered media environment, and strong competition from product advertising. Overall, (142) has argued that, with the exception of campaigns that focused on drunk driving, there has not been much success. Most importantly, the thesis has shown that despite the CSR messages from the alcohol industry in Botswana, and its complaints about not being consulted in the policy development process, the industry has lobbied *against* the Alcohol Levy and also threatened government with legal suits stressing their

frustrations that they were not consulted when the levy was introduced (see Chapter 6).

The study findings show there has been a lack of continued or consistent political support and leadership to address the harmful use of alcohol in the country. Furthermore, the tax levy collected from alcohol sales has been used for unintended purposes and the promises made to construct rehabilitation centres in the country has not been fulfilled; this idea remains as annual rhetorical statements, reported in the State of the Nation Address (SONA) each year. The negative consequences of the misuse of levy funds continues even up to today. Weak government leadership and structures coupled with a profit-driven industry and ill-thought through policy (levy) actually had unintended consequences, leading to a worsening situation with regard to alcohol consumption (a rise in binge drinking and cases of alcohol-related violence in the country).

7.2.6 Donor funding flight and agenda setting: the conundrum

The implementation of HIV/AIDS programmes in the country owed much to the financial and technical assistance of external donors and international agencies such as the Bill and Melinda Gates Foundation, as well as internal financial support from the government and then Botswana National AIDS Coordinating Agency (NACA), now Botswana National AIDS and Health Promotion Agency (NAHPA). However, the response to NCDs has not received the same support from donor funds or developmental partners just like it was the case in the response to HIV/AIDS. In Botswana, NCDs have not received the same from donor funds and international agencies as it was the case in the response to HIV/AIDS. The study findings have shown that before 2019, there was no financial support for NCDs, and neither were they budgeted for, unlike it was the case with HIV/AIDS. It was only recent that NCDs were included in the country's National Development Plan Eleven (11) and in the 2019 budget at national level, but not at the sub-national level. Despite the significant attention NCDs have received, progress towards global goals and financial support and commitment remains disappointing. Despite this, development assistance for NCDs remains a tiny proportion of overall development assistance in health (DAH)

funding, (42, 143). Furthermore, the study findings has established that future funding for NCD responses, both domestic and external funding, is still unpredictable.

Scholars have contrasted the response of the international community to HIV, following the UN General Assembly's Special Session on HIV/AIDS in 2001 (UN General Assembly), with the High-Level Meeting on NCDs in 2011 (UNGASS),(2). Despite rising faster in young populations and causing death earlier in low- and middle-income countries than in high-income countries NCDs continue to attract the lowest share of global Development Assistance in Health (DAH) among key health focus and program areas, (144). The study findings also indicates that donor funding and assistance to HIV/AIDS also created dependency syndrome to volunteers and civil society organisations something which is not prevalent now in the response to NCDs living hope that someone will intervene and assist.

This thesis has established that the allocation of financial resources towards the development and implementation of NCD responses at national and sub-national levels remains a challenge. The findings show there is a need for leadership and greater accountability to support these resource allocation processes. Additional funds will be required to target and meet the changing disease burdens caused by NCDs and their underlying risk factors, such as rehabilitation for alcohol and substance abuse, and surveillance for and treatment of high blood pressure which has increased in the country. The study findings indicate that expanding annual health budgets earmarked for NCDs at national and sub-national levels is critical. However, traditional funding approaches (e.g., domestic tax revenues), though a common source of health funding in the country and other countries in low- and middle-income countries, have been described as inadequate to close the funding gap required for NCDs, (118). In this context of limited resources, the role of innovative financing mechanisms (e.g., pooled funding) to mobilize alternative financing strategies to support the prevention and management of NCDs may be useful to consider, (145).

Donor funding support for disease responses can be vital, as was the case with the HIV/AIDS response in the country. But dependence on donors for funding disease responses can, however, raise problems. Studies conducted by Sharma & Seleke, (12),

(146), and (147) indicate that international donors and multilateral agencies have influenced the health policy agenda in the response to HIV/AIDS as well as malaria and maternal health. On the other hand, (148) has stressed that such influence by international donors and multilateral agencies has given rise to a donor dependence, as donors are the ones who determine the key priority areas for response, and fund that response, because they are the ones providing the funds.

Botswana's response to HIV/AIDS was very vibrant and effective. (12) supports this argument and stressed that government efforts to overcome the epidemic were favourably supported by the international community of donors, multilateral agencies and non-governmental organizations (NGOs). As a result of this, in 2001, Botswana developed a comprehensive HIV/AIDS treatment model affectionately dubbed "*the Rolls Royce Model*" or Masa "New Dawn", partnering with the African Comprehensive HIV/AIDS Partnerships (ACHAP), and initiating free antiretroviral (ARV) treatment programmes for its citizens, the first to do so in Africa, (12). ACHAP is a public-private partnership involving Merck and its foundation, the Bill and Melinda Gates Foundation, and the Government of Botswana (12). Furthermore, the country partnered with Harvard University forming the Botswana Harvard Health Partnership in 1996, a leading HIV/AIDS research, training and capacity building institution.

The study findings have shown, however, that the country is now facing a donor funding "flight", creating serious challenges, as donor funding for its HIV/AIDS programmes has been reduced; the Bill and Melinda Gates Foundation has scaled down its support and ACHAP has stopped its activities. America's CDC also stopped activities. These reductions in support are mainly because of the country's re-classification as an upper-middle income country. The effects of the donor flight are then equally felt by the implementing CSOs in the country whose funding is highly dependent on donors. At this time, they have reduced funds and study participants argued they lack the financial capacity to invest heavily in NCD responses.

7.3 Implications and Contribution to Knowledge

This study contributes to knowledge in different ways. First and foremost, the PhD addresses a key gap in knowledge, by contributing new empirical and conceptual

understanding about NCD policy development processes in Botswana and the wider region. To date there is a gap in scholarly work and understanding about NCD policy responses in sub-Saharan Africa, demonstrated in the literature review, about how LMICs are responding to NCDs and NCD risk factors. There are limited studies which have paid attention to policy processes for responding to NCDs and their risk factors, including a lack of policy alignment and actor coordination. This PhD thesis is the first of its kind in the country and there are few others focused on the Africa region.

The PhD thesis, being the first in the country to research NCD response policy development, has contributed to empirical understanding about NCD policy processes, and to wider knowledge about health policy processes in Botswana. Using the Shiffman and Smith framework, which has four different domains, the thesis has shown how the framing of the NCD policy problem, the policy context and the policy window, and the NCD issue characteristics, have influenced policy development. It demonstrated how the UNGASS 2011 Political Declaration and the WHO 2013-2023 "Best Buys" created an important policy context and window which influenced the development of the Botswana National Strategy for the Prevention and Control of NCDs in 2018 in the country. The global agenda also meant that for some civil society organisation groups such as Lesbians, Gays and Bisexuals of Botswana (LEGABIBO), responding to NCDs and risk factors became a matter of human rights (Chapter 6), where they called for clear detailed guidelines for use with their population groups.

The thesis has contributed empirical knowledge about the policy actors involved in the NCD response (or limited response). Notably, the MoHW has played a dominant role in the policy response, but this was also accompanied by restricted participation by other policy actors; yet wider or inclusive participation in the policy process is seen to be beneficial for effective policy design and subsequent implementation feasibility. This was exemplified by the study respondents from civil society organizations and private sector actors, who argued that they were not consulted, nor did they form part of the Technical Working Groups (TWGs) during the development of the Botswana National Strategic Framework for the Prevention and Control of NCDs. However, by excluding some of the civil society groups and the private sector, the government positioned itself as the overall steward, proactive and more concerned with NCDs than

other stakeholders. But this non-consultative process led to poor coordination, weaker leadership, and non-engagement or even resistance by those who were not consulted in the development of the NCD strategy. Notably, the thesis also highlighted the influence of alcohol industry actors. The interests of the alcohol industry (largely sales and profits) are in tension with public health interests, and so industry actors have played a role with constant lobbying and instances of litigation against the government. Alcohol industry actors argued that they had not been consulted by the MoHW, as noted above, which meant they needed to resist what they considered the poorly thought-through Alcohol Levy, but they stressed that they were now actively engaged through corporate social responsibility actions, and partnerships with international agencies such as Rutgers, to overcome NCDs, particularly cancer.

Second, the thesis provides a clear case study of how the rhetoric about multi-sector approaches to build coordination for a common goal and purpose in the response to NCDs seems to be failing. The UNGASS 2011 Political Declaration and the 2013 WHO "Best Buys" recommends that multi-sectoral approaches be adopted by member states in the response to NCDs and risk factors. In the case of Botswana, however, multi-sector approaches have not worked, partly because the structures in place are still focused on the vertical and programmatic response to HIV/AIDS, with limited funding for broad-based system-wide NCD responses and no budget at the sub-national level.

Third, this thesis also demonstrates that although the government has taken positive strides by developing the Botswana National Strategy for the Prevention and Control of NCDs, and the willingness to respond is there, key implementation weakness remain. Thus. the strategy is not linked to service delivery and related budget allocations. This implementation weakness is a consequence of a policy context or landscape, in which there are no policy champions for the NCD response, as was the case in the response to HIV/AIDS. Civil society organisations and other organisations are now working in siloes as there is lack of clear leadership and clear parameters to push for a multi-sectoral response to NCDs, as was the case with the response to

HIV/AIDS. These organisations have developed their own guidelines and run some NCD programmes that are parallel to that of the government.

Finally, this PhD thesis has offered some insights into how health policy development is influenced by the way power is exercised, including how diseases and policies are framed by policy actors through the policy process, (38). It shows that in Botswana, the Ministry of Health and Wellness has overall power and authority in health policy, but that this can have advantages (e.g., opportunity to implement ambitious strategies and lead others) and disadvantages (e.g., exclusion of key non-state actors). It also provides empirical evidence on how actors and non-state actors perceived or how they framed NCDs, for example with respect to the Youth Council in Botswana which viewed NCDs as the disease of the elderly, and so took limited action against health-damaging behaviours amongst youth which could lead to NCDs in the future.

7.4 Reflections on the Conceptual Framework

The study employed Shiffman and Smith's framework to understand why some global health initiatives in Botswana have been more successful in generating funding and political priority than others. Walt and Gilson point that Shiffman and Smith's framework's primary aim is to assess how far the component parts of the framework help to identify the factors that influence the agenda setting stage of the policy process at global and national levels (33). The authors argued that the framework seeks to advance the field and inform the development of theory in health policy and is useful for organising and analysing data. This framework was selected as the most appropriate given the focus of the thesis, and used to formulate the research questions, collect data, and conduct the analysis. Furthermore, it also illustrates that the notion of guiding institutions would benefit from being separated into two concepts: guiding institutions in terms of their power as actors; and the formal and informal norms and rules that underpin judicial and legal institutions which are part of the political context.

Other related and similar frameworks were drawn upon in this thesis, including Kingdon's Multiple Stream framework and Walt and Gilson's Policy Triangle. Kingdon's multiple streams framework is one of the most used conceptual tools for

understanding the process of policy making, including policies in the field of healthcare (34). According to Behzadifar et al. (34), scholars use this framework to gain a fuller understanding of the policy-making processes, including how they are developed and implemented. According to Kingdon's model, public policy is made up of three independent streams: the problem stream, the policy stream and the politics stream, (35) and these have been used to examine national policies such as the essential medicines policy in sub-Saharan Africa (36). Walt and Gilson's policy analysis triangle framework was used to analyse the policy-making process in the prevention and control of cardio-vascular disease (CVD) in Iran at the secondary and primary prevention levels, (33). The results of this study were presented in accordance with the triangle of policy analysis in the four main dimensions of this framework (i.e., actors, content, context, and process) in Khodayari et al. (40).

The frameworks and theories take into account the policy cycle or stages approach widely used in exploring the policy process. Hoefer (39) argues that Kingdon's multiple stream framework's major limitation is its ambiguity in relation to problem definition, in that different actors define the same situation differently, so maximal clarification or definition of the goal is very difficult. The final assumption in the MSF is that independent processes occur when policy decisions are made. The other limitation of the MSF is its assumption that policy problems, policy solutions, and political conditions are constant; however, these processes or contexts shift constantly and without clear linkages to each other (39).

A shortcoming of Shiffman and Smith's framework is that it is silent on the participation of the private sector in the policy development process. It also does not include or focus on the power that non-state actors can have at national policy development process fora, which most consider to be state dominated.

As discussed earlier in the thesis (see Chapter 2, Conceptual Framework), I selected the Shiffman and Smith's framework for this study because it provides an approach to examining the gaps in the political prioritisation in developing policy. The Framework has been used at a global level (27) and I wanted to test its utility for national policy analysis in the response to NCDs and risk factors in the country. The Shiffman and Smith framework consists of four components: actor power, the ideas

used to describe the issue, the context within which the actors are operating, and the characteristics of the issue itself. I used the framework to investigate how NCDs policy development has been carried out in the response to NCDs by exploring the actors involved; the ways in which NCDs has been understood; the severity and prevalence of the issue; and the political context in which NCDs has developed. To assess the domain on actor power, the thesis looked at the factors shaping the country's policy priorities. This was carried out by conducting research interviews with key actors to examine, first, actor interests or actions and the guiding institutions and their sources of power in the development of the NCD policy response. It specifically looked at the role they play and examined whether the Ministry of Health and Wellness has the same energy and drive in the response to NCDs as was the case in the response to HIV/AIDS. The three main domains by Shiffman and Smtih are discussed below:

The second domain of the Shiffman and Smith are ideas framing the issue. That is, how was the problem of NCDs framed by the diverse actors involved, particularly among the NGOs and its possible solutions and policy responses. Shiffman and Smith argue that some health campaigns are easier to promote than others because the diseases they address are seen to be more harmful, *(27)*. Shiffman and Smith's ideas framing the issue domain indicates that an issue can be framed in several ways and that the different frames appeal to different audiences with some frames resonating more than others. It also provides for internal and external framing, where collective action and the identification of ideas are key. The internal framing is distinguished from external framing in that the former focuses on the causes and solutions to the problem as well as the agreement between the actors, while the latter looks at those in power and in the way the issue is portrayed.

The third domain of the Shifman and Smith's is the context. The political context refers to the environment in which the actors operate; it includes the ability of global actors to take advantage of policy windows to influence decision makers. This domain overlaps and shares more commonalities with actors' power and networks, and demonstrates how the actions that have to be undertaken by the actors are circumscribed by context.

The last domain of the Shiffman and Smith's framework refers to issue characteristics, (27) and it looks at three factors: (a) credible indicators, which are clear measures that show the severity of the problem and can be used to monitor progress; (b) severity, where the focus is on the size of the burden of the disease relative to others; and (c) effective interventions, whereby the extent to which the proposed means of addressing the problems are explained in terms of how they are cost effective, backed by scientific evidence, simple to implement, and inexpensive. The characteristics of a policy 'issue' include the extent to which credible indicators or data are available to assess the size of the burden compared to other problems, (149). In order for an issue to get onto the policy agenda, it needs be recognized as a concern, often through clear measures that show the extent of the problem, (150).

7.5 Study Limitations

This thesis has several limitations. First, despite trying to interview a broad range of actors from different organizations, I was unable to interview some key policy actors, including leaders of the National AIDS and Health Promotion Council, the former President of the Republic of Botswana and policy champions against HIV/AIDS, plus some parliamentarians, academics and actors from other sectors outside of health such as the leaders of Vision 2036 whose insights would have contributed to shaping the thesis narrative. Representatives from the tobacco industry and some from the alcohol industry either did not reply or refused invitation to participate.

Data collection was disturbed by the unprecedented outbreak of COVID-19 and the travel restrictions which meant that all interviews were conducted virtually from London, UK. The challenges also included difficulties in recruiting and interviewing key high-level individuals and certain institutions and international agencies. Some refused to partake in the research study due to concern of being part of the virtual interview. Making contact and securing the interviews took longer than usual.

The changed institutional environment due to COVID-19 also led to significant delays in receiving ethical approvals from the London School of Hygiene and Tropical Medicine, the University of Botswana Ethical Review Board and the Ministry of Health and Wellness Ethical Review Board. To mitigate these limitations, additional

documentary analysis was used to fill information gaps in parallel to conducting interviews. There were also challenges in obtaining relevant documents from website portals and repositories, which were mostly not up to date and lacked relevant information such as key strategies.

Despite this, the data collected were rich and many respondents were knowledgeable and open about the shortcomings of the NCD response. This allowed for in-depth analysis, reaching data saturation and deriving themes that were triangulated and validated using different data sources.

7.6 Proposed Outputs and Dissemination

The findings of this PhD thesis will be presented through roundtable discussions linked to the policy process in Botswana, and through development of academic and policy papers which will seek present lessons and strengthen NCD policy development in Botswana and in sub-Saharan Africa more generally. It will also engage with researchers conducting NCD policy analysis, and inspire future research on the topics of health system transformation to address the burden of NCDs, and moving away from vertical programmes to health system strengthening.

7.7 Recommendations for Policy

The thesis findings and analysis generate several lessons for policy and practice, summarized below.

- There is a need to create more inclusive platforms to convene actors and provide opportunities to have open dialogues linked to the policy processes and the implementation of reforms to address NCDs. This can improve policy alignment and coherence and ensure that all actors have a shared understanding of their roles and responsibilities. A similar platform has facilitated the effective HIV/AIDS response.
- Health sector-wide and inter-ministerial NCD response structures need to be established to ensure that the multi-sectoral approach envisaged in the NCD strategy can be implemented and the much-needed technical capacity for NCD responses built – essentially a need for a 'whole of government' vision. However, it

will be critical that these NCD-specific structures not only provide technical advice on the suitability of different proposed interventions and the research needed, but more importantly focus on strategizing, guiding, and coordinating policies and activities across different stakeholders within and beyond the MoHW and NAHPA.

- However, resources are needed to strengthen institutional capacity to respond to NCDs, but these resources should, however, not be solely targeted to NCD-specific units, but equally, to the inter-ministerial NCD units. This will enable the achievement of stronger multi-sectoral coordination in line with the 2013 WHA resolution, enacting a Global Coordination Mechanism for NCDs (GCM/NCD) to facilitate engagement between Member States, UN agencies, other relevant inter-governmental partners and non-state actors in order to enhance collaboration across sectors at national, regional, and global levels, to ensure effective NCD responses and prevent the potential for conflicts of interest(1, 81).
- The District Health Management Teams (DHMTs) and other sub-national structures would need more resources and technical expertise, and incentivized to implement the NCD plans and manage NCD-related activities. These need to be located within a strengthened PHC system rather than operating as vertical programmes, as was the case with HIV/AIDS.
- The culture of donor dependency, relying on external assistance and replicating the model of organising the health system as a set of multiple vertical programmes, needs to be gradually changed with the realization that effective NCD responses require health-system-wide responses. Thus, it is insufficient to have an NCD strategy in isolation from an overall move towards adopting universal healthcare coverage for PHC that can ensure that NCD services more available, accessible and affordable. This means enabling conversations and collaboration between different policy actors and constituencies.

7.8 Recommendations for Further Research

This PhD study has shown that Botswana is not on track to meet the time bound target on NCDs in the SDGs to reduce premature mortality from NCDs. As a result of that, further health policy and systems research analysis on the policy development response to NCDs and risk factors is urgently needed to gain additional insights into

this complex process. Research should also address the issue of how to build on the political support and action by key government institutions, ensure gaining support by other key actors and policy processes, and ensure that advanced technical expertise for the prevention and control of NCDs is built at sub-national level to implement these strategies.

There is also a need for both policy-related and community-based research to better understand what innovative policies can better motivate and facilitate multi-sectoral collaboration, enhance actors' buy-in into the process and community engagement. Research should also explore how to develop genuine accountability mechanisms and procedures to assess the performance of the guiding institutions and political leaders in leading whole of government response to NCDs and risk factors.

7.9 Overall Conclusion

This thesis provides a policy analysis of national responses to the growing burden of NCDs in Botswana – the first study of its kind in the country to do so – aiming to inform policy development and the health system transformations required. It demonstrates the need to address key weak points such as developing integrated and implementable solutions that ensure that the NCD responses are built within an effective PHC system rather than treated as vertical programmes such as HIV/AIDS. To achieve this, the thesis demonstrates the need to strengthen the capacity of government at central and sub-national levels, recognize actor incentives and create a common policy framework (with resources attached to it) for them to work together. The thesis also contributes to the evidence base supporting the need to reorient health systems in Africa towards supporting NCD care, specifically examining the policy development processes for achieving that; an aspect that has received insufficient attention so far.

Two specific areas of weakness identified and which could be addressed relatively quickly are, first, that the Botswana National Strategic Framework for the Prevention and Control of NCDs, introduced relatively recently, has not yet been operationalized and linked to health services delivery. For example, it has a limited budget at the

national level and no budget at all at the sub-national level. Second, there are also no provisions for training staff who can implement the NCD policy.

A key challenge for the government is that NCDs, unlike HIV/AIDS, are not homogenous but are comprised of four broad disease categories: cancer, diabetes, hypertension and cardiovascular disease, with each category having different care requirements and actors advocating for improvements. Each requires a robust framework and policy response, but they also need to be coordinated and well-aligned, which needs to happen urgently if the country is to address effectively the NCD burden.

ANNEXES

Annex A: The process of selecting the articles

Annex B: Sample data extraction table for the exploratory review

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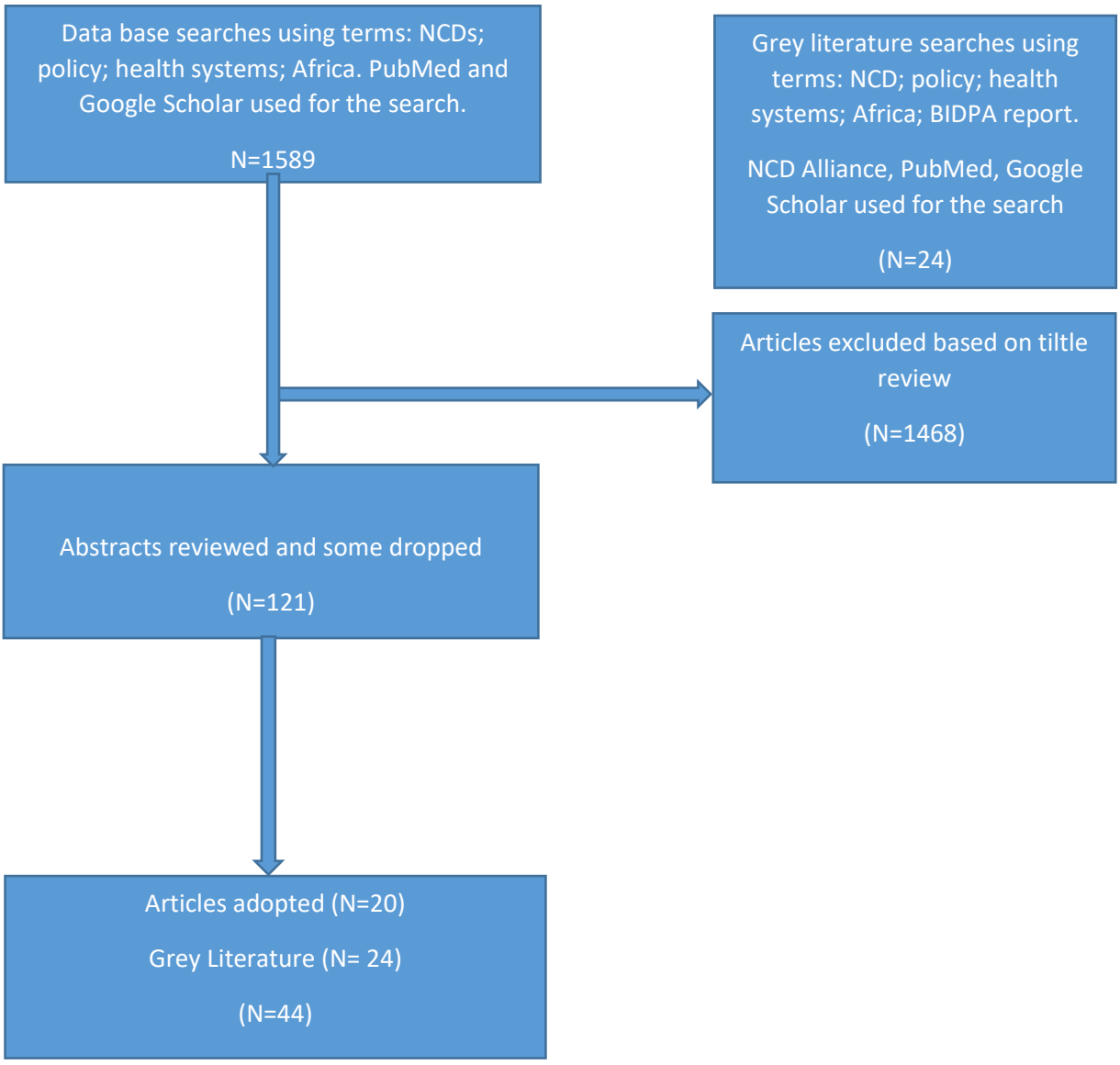
Annex A: The process of selecting the articles for exploratory review



Annex B: Sample data extraction table for exploratory review

Author & Title	Approaches	Methods	Findings	Shiffman & Smith framework	Key Words
1: Sanni S, Wisdom JP, Yusuf A, Hongoro C, 2019. **Multi-Sectoral Approach to Non-Communicable Disease Prevention Policy in Sub-Saharan Africa: A Conceptual Framework Analysis**	The review assessed constructs from current frameworks & theories of health policy analysis. Develop a preliminary synthesis of findings from selected frameworks & theories. Applied overarching framework to analyse tobacco control policies in Togo & in South-Africa.	Qualitative studies which used MAP to analyse tobacco control policy process in Togo & South Africa. To develop a preliminary synthesis of findings from the selected frameworks & theories.	The findings highlight the need for context specific political mapping identifying the interests of all stakeholders & strategies for interaction between health & other sectors when planning policy formulation or implementation.	**Actor Power:** Networks & advocates: Identifying the interests of all the stakeholders & development of strategies when planning policy formulation & implementation**. Political Contexts:** Highlight the need for context specific political mapping**.**	Tobacco control in Togo & South Africa. Health Policy Analysis
2: Abiona O, Oluwasanu M, Oladepo O et al., 2019. **Analysis of alcohol policy in Nigeria: Multi-sectoral action and the integration of the**	Their study looked at the utilization of WHO "Best Buys" intervention & MSA in the formulation of policies in the response to NCDs, specifically harmful use of alcohol.	Scooping review, Google Scholar, Science Direct and Pubmed to identify articles and policy documents.	They revealed that policy actions to address harmful alcohol use are proposed in the 2007 Federal Road Safety Act, the Prevention & Control policy in the strategic plan of action.	**Issue Characteristics** It looks at how the issue is characterized & described in trying to draw attention to it. Their study reviewed in-depth analysis of alcohol related policies.	Harmful Alcohol Use Policy formulation Strategic plan of action Prevention & Control

WHO "Best buys" interventions.			Only one of the WHO "Best Buys" interventions (restricted access to alcohol) is proposed in these policies. Multi-Sectoral Action for the formulation of alcohol-related policy lies low & several relevant sectors with critical roles in policy implementation were not involved in the formulation process. Overall, alcohol currently has no holistic health sector-led policy document to regulate the marketing, promotion of alcohol & accessibility.	**Political Context**: Utilization of WHO "Best Buys" & MSA in formulation of policies.	
3: Shiroya V, Neuhann F, Muller O et al., 2019. **Challenges in Policy Reforms for Non-Communicable**	Their study presented Kenya's experience of translating the UN Declaration to National policies for prevention & control of diabetes.	Policy documents reviewed; those published between 2006-2016 were analysed.	The findings showed that diabetes specific policies existed in Kenya before 2011, suggesting successful advocacy by diabetes interest groups.	**Political context**: Highest political level needed to address overarching NCD drivers. **Actor Power: Networks & advocates:** Non	Diabetes Prevention & control Policy Implementation Health policy National strategy

Diseases: The case of Diabetes in Kenya			Policy window opened up during this period. Community leveraged towards the bigger political drive against prevailing challenge. Most of the documents & national strategies aligned strongly with international documents, however, were based on local evidence.	health sector remained uninvolved, contrary to global recommendations.	
4:Juma P, Mohamed S F, Mwagomba M et al, 2018 **Non-communicable disease prevention policy process in five African countries**	Their paper described NCD prevention policy development processes in five countries – Kenya, South Africa, Cameroon, Nigeria and Malawi. They state that NCD prevention policy development/process in many African countries has been influenced both by global and local actors. They state that countries have the will to develop NCD prevention policies, but	Study Methods: multiple case design, with each country as a separate case. Data collected through document reviews & key informant interviews with national level decision makers in various sectors. Data analysed thematically guided	Country level policy has been relatively slow and uneven. Policy process for tobacco has moved faster, especially in South-Africa but was delayed in others. Alcohol policy process has been slow in Nigeria & Malawi. Existing tobacco & alcohol policies address the WHO	**Actor Power**: **Network & Advocates**: They single out inadequate political commitment. Acknowledge the notion of policy transfer from global to local to influence policy development. **Issue Characteristics**: The countries have the will to develop NCD prevention policies but they face	Alcohol & Tobacco policy process Prevention Policy development process Strategic Plans

	they face implementation gaps and need enhanced country level committees to support NCD prevention policy development. They assessed the extent to which WHO "Best Buys" interventions have been implemented and generated evidence on the extent of Multi-sectoral Action (MSA) applications in NCD prevention policy development, focusing on policies around the major risk factors	by Walt & Gilson's framework.	"Best Buys" interventions to some extent. Physical activity policies are not well developed in any study country. All have recently developed NCD Strategic Plans consistent with WHO Global NCD Action Plan, but these polices have not been adequately implemented due to inadequate political commitment, inadequate resources & technical capacity as well as industry influence.	implementation gaps. Physical policies are not well developed	

Annex C: Summary of the literature review findings

Elements	Factors shaping policy priorities	Status of NCDs & Risk Factors from the study countries
Actor Power	**Guiding Institution**: The National governments through the Ministry of Health in the various sub-Saharan African countries in the different study countries played a major key dominating role. Leadership: Civil society Private Sector/Policy Community	No strong coordinating mechanism by the Ministry of Health. The global declarations and WHO Action Plans not adopted in whole. The declarations provided guidelines as to who has to be involved, how & mechanisms for the roll out from the national to sub-national level. There were discrepancies and non-compliance with the global actions, declarations and treaties. MoH Leadership gap, very weak and no political commitment & resources. Minimal participation of civil society save for the Kenya study on diabetes, where the diabetes group played a successful advocacy role. The UN Political Declaration on NCDs & treaties highlights the critical role civil society plays in the prevention and control of NCDs. But civil society not involved & there is very little detailed analysis as to why that was the case in the different country studies. Not consulted, for example in Botswana. The alcohol policy did not achieve its intended objectives.
Ideas Framing the issue	**Internal Frame**: The promotion and framing of a common construct has not been difficult in the response to NCDs and risk factors, i.e., harmful use of alcohol and tobacco. There is an agreement within the policy community that the NCDs & risk factors are the leading cause of	Difficulty generating the response as the papers cite many emerging challenges.

	morbidity & mortality that needs to be addressed. **External Frame:** Public portrayals of the issue that resonate with the external actors, especially the political leaders, who control resources.	Still being developed and tested as the different study countries are showing lack of political leadership & resources to enable them an effective response.
Political context	Policy Windows: the political moments that present opportunities to influence decision making. Global governance	UNGASS 2011, WHO "Best Buys", Framework Convention on Tobacco Control & Alcohol Policy. These were such a policy window. UNGASS, WHO "Best Buys" Intervention, declarations and guidelines.
Issue Characteristics	Credible Indicators Severity Effective Interventions	NCDs & Risk factors more difficult to measure than many other health outcomes. High morbidity & mortality of NCDs and Risk factors. High harmful use of alcohol and the policy responses did not bear fruit as was the case in Botswana. Development of policies & strategies although with challenges.

Annex D: Illustration of the application of Shiffman and Smith's conceptual framework

Domains	Factors shaping policy priorities	Description & Examples
Actor Power	These will be carried out through the interviews, the primary motive being to carry out the investigations on the following: **Guiding Institutions**: To investigate how they are involved. - What role do they play? - Does the Ministry of Health have the same energy and drive in the response to NCDs as was the case with HIV/AIDS? - Why is there a difference, if at all any? - How do they carry out the coordination role? - How do they interact and work with other actors? - When and how often do they meet? Do they meet or not? - How do they work with them? **Leadership:** This forms part of the triangulation process. - Who is involved? - Identify who is involved in the key actors' leadership roles. - What activities do they carry out? - How do they interact with other actors?	In Botswana for example, the guiding institution in the NCD response is the Ministry of State President, which works closely with the Ministry of Health. The National AIDS & Health Promotion Agency (NAHPA) is responsible for the coordinating role and has maintained the same multi-sectoral structure that was used in the response to HIV/AIDS, working closely with the community and industry. Previously the NCDs unit was housed at the Ministry of Health and it has since been moved to NAHPA which came as a result of the National Strategic Framework for NCDs 2017-2023. According to the MoH, UNDP & WHO Report on Botswana National Alcohol Policy (2017), the Alcohol & Substance Abuse Division that oversees the implementation of the National Alcohol Policy and drives the national alcohol response is overstretched and often cannot cope with the workload nor can it be reasonably expected to drive a robust and effective national response to alcohol abuse. The

	Policy Community: Who is involved in the process of policy development? - What is policy making? Is it formal or informal? - Do the actors feel they can go it alone in the process of policy making or not? **Civil Society**: Identify who is involved in the process of policy development. - Determine the extent and the magnitude of social mobilization. - Make an assessment of the annual reviews & the meetings. - Who is invited and why? - Are there mechanisms to involve community groups? - Who are the civil society actors and why are they selected?	division lacks the capacity and the manpower to achieve its mandate. The intersectoral committee does not meet as regularly as it should, nor does it play a role effectively. The MoH plays the role of the implementor as well as the coordinator. It coordinates its own activities and the activities of other parallel Ministries under the overall Strategic Framework of the National Alcohol Policy 2010. The coordinating role is done by NAHPA.
Ideas framing the problem	**Internal Frames**: The degree to which the policy community agrees on the definition of, causes of and solutions to the problems. **External Frame**: Public portrayals of the issue in ways that resonate with the external actors, especially the political leaders who control resources. - Do you think you and the people you are working with understand what constitutes the problem? - Do you agree that there is a problem?	The overarching finding from the literature in Botswana is that it not clear how the issue has been framed in relation to the response to NCDs, however there is an acknowledgement that NCDs and risk factors (especially harmful use of alcohol and tobacco) are the leading causes of morbidity and mortality in the country. This is amplified by the development of the National Strategic Framework on NCDs 2017-2023 as well as the National Alcohol Policy 2010. The greatest challenge is that although the burden of NCDs is increasing in the country, not much

	- What do you think are their perceptions on what they see as a problem? - How do the people understand the problem?	commitment has been made to respond to the issue, as was the case with the response to HIV/AIDS. Although Botswana is a signatory of the international treaty and conventions, it was only in 2016 that the country established a National Strategic Framework on NCDs.
Political context	**Policy Windows**: Political moments when conditions align favourably for an issue, presenting opportunities for advocates to influence decision making. **Global governance structure**: The degree to which norms and institutions operating in a sector provide a platform for effective collective action. - Why are you doing it now? - Are there any priorities? - What is influencing their behaviour? - What is the extent and participation of the donors? - Are they coming with money? - Are the donors exerting any pressure or not?	Political moments that present opportunities to influence decision making in the response to NCDs and risk factors were created by the UNGASS 2011, WHO "Best Buys" interventions, Framework on Tobacco Control (FCTC), the Global Policy on Harmful Use of Alcohol, and the SDG 3.4. Although Botswana acknowledged that NCDs were the silent epidemic that needed to be addressed, they developed the National Strategic Framework on NCDs only in 2016. Up to that date, the only national policy instruments related to NCDs were the Alcohol Policy, Botswana Public Health Act and Essential Health Services Package – but these did not comprehensively address NCDs. There are still many challenges with respect to ensuring political commitment and funding, in contrast to the response to HIV.
Issue Characteristics	**Credible Indicators:** The extent to which there are credible indicators that can be used to assess severity and monitor progress. - What is being done to respond to the disease burden? - Measurements.	The literature on NCDs and risk factors in Botswana acknowledges that NCDs and risk factors are the leading causes of morbidity and mortality in Botswana. It is reported by (29), (10), and the Botswana Steps Survey that NCDs account for 37% of deaths in the country. The prevention and control of NCDs has been prioritized and included in high level

	Severity: Acknowledgement that NCDs are the leading cause of morbidity and mortality. - What is being done to respond to NCDs? - Are there any policies & strategic frameworks developed to address them? - When were they established and is there funding for them? **Effective Interventions:** The policy outcomes. How countries in Botswana and SSA responded. - Human resources and infrastructure availability. - Funding etc	National documents such as the 11th National Development Plan 2017-2023, Ministry of Health and Wellness Strategy 2017-2023 and the National Essential Health Service Package. Before 2016, a National Policy or Strategy on NCDs was lacking. A successful response to the emerging NCD epidemic will require interventions as noted by Reid et al. 2012 such as training of health workers to deliver high quality disease specific care. They observed that in Botswana the primary care response to NCDs is unstructured and inadequate. They also emphasized the need to build strong partnerships and community mobilization to support NCD prevention messages and diffuse health-related knowledge. To ensure that NCD prevention interventions are effective, it is essential that community groups are integrated. They also emphasized the need to develop public-private partnerships to strengthen NCD services across industry inclusive of the business sector to help improve NCD outcomes.

Source for framework: Shiffman and Smith (2007)

Annex E: Key institutions, actors, and evidence types

Institution	Rationale	Type of respondents to be interviewed	Documents to be reviewed	Routine information, statistics	Public information/ Media
Ministry of Health (MoH)	Actor domain: - Leadership - Convening meetings - Coordination – Multi-sectoral approach & involvement of key stakeholders - Experts and technical support groups - Development of national strategies and policies Community Mobilisation	Permanent Secretary MoH Director Health Services – Head of NCDs Alcohol Division: Advisor, Community Health Services Chief Health Officer, Alcohol and Substance Abuse Chair: Alcohol Policy Committee. Ministry of Finance NAHPA – National AIDS & Health Promotion Agency	National Health Policy Botswana Multi-Sectoral Strategy for the prevention and control of NCDs 2017-2023 National Alcohol Policy Minutes of meetings Grey literature BIDPA Reports on alcohol policy	National Statistics office and various research papers and think tank reports	Critical commentaries or programmes on the role of the MoH relevant to NCD
Civil Society	Actor domain: - Mobilising - Representing communities - Channelling grassroots concerns	BOCONGO, Chair BOSASNET: Chairperson Anti-Tobacco Network Cancer Association of	Annual reports Publications Websites		Commentaries on the participation and the role of the civil society in the response to NCDs. Is there commitment and

	- Fostering partnerships between civil society - Technical support - Advocacy role - Implementation and monitoring - Trigger political drive	Botswana Diabetes Association			community mobilization as there was with HIV/AIDS response?
Industry	- Promotion of the healthy workplace - Improve affordability - Access to medicine	Botswana Alcohol Association, Liquor retailers Tobacco Industry and dealers	Annual reports Stakeholder meetings Workshops		Critical engagement of the industry on their role. Community Social Responsibility engagement and outcomes.
Donor organisations	- Funding - Influence - Technical support - Expert support and influence	WHO, UNDP & BIDPA country representatives. Project officers working on issues relevant to NCDs SADC	Country reports and performance Meetings records		Critical reports on the extent of their participation and involvement. Do they call the shorts or just there to provide expert and technical support.

Annex F: Information sheet and consent form

Information sheet

Study title: Understanding and Improving the policy process as a critical element to addressing NCDs: the case of Botswana

1. What is the purpose of the study?

The aim for the PhD research is to explain the policy responses to NCD, their adequacy and in view of the growing NCD burden in Botswana. It also seeks to examine how international recommendations such as the UNGASS 2011, Political Declaration to national policies for the prevention and control of NCDs and risk factors and WHO's "Best Buys" interventions have (or have not been) informed and unpinned national policies. The case study of Botswana will provide illustrations of the key themes that can be explored in other LMICs settings.

2. Taking part in this study

From August 2020 to Feb 2021, I will be conducting a research study in Botswana related to the above-mentioned title. Through the literature review, I have identified you as an important policy actor in the health system, I would very much appreciate your participation in this process. It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form. Your participation is entirely voluntary, and you do not have to answer any questions that you feel you do not want to.

If you agree to participate, I would like to interview you and ask questions related to your experiences to do with NCDs in this country. The interview will take 30 – 60 minutes but will vary based on your level of involvement.

3. Your confidentiality

All information collected about you during the research will be kept strictly confidential. With your consent, I would like to digitally record the interview, so that myself and the research

assistant can make written transcripts of what was discussed. All the electronic data will be stored in a password-protected file.

You will also be asked to give consent for to use anonymised quotations of anything you might say (without using your name) so that I will use this in any peer-review publications arising from this study. While we will endeavour to ensure that no statements are linked back to you, it may not be possible for us to guarantee complete anonymity. Please let us know if you do not wish to be quoted even anonymously.

4. What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time, in which case any data collected from the interview will be removed from the review and analysis.

If you have questions about the research in general or about your role in the study, please feel free to contact me (see end of form).

5. What will happen to the results of the research study?

The information gathered will be used to improve the response to the growing burden of NCDs in Botswana. It will form part of my PhD but will also be written up in journal articles that can be shared with other African countries, to learn from Botswana's experience. Before publication of a case study, it will be shared back to be sure that my interpretation is correct. There will be no financial compensation for your participation in this research**.**

6. Who is organising and funding the research?

The Principal Researcher although has full funding from his employer, the University of Botswana may apply for additional funding to the LSTM PhD scholarship for additional BWP 4000 to support the hiring of local research assistant. The LSHTM email address will be used for all correspondence relating to the research.

7. Who has reviewed the study?

This study is subject to the ethical approval and oversight of the London School of Hygiene and Tropical Medicine Research Ethics Committee, University of Botswana Ethical Review Board and the Ministry of Health Ethical review Committee

8. Contact Details

PRINCIPAL INVESTIGATOR: Mr Thabo Lucas Seleke, Mr Lucas Thabo Seleke - Thabo.Seleke@lshtm.ac.uk, phone: +447424873587 / WhatsApp: + 4424873587 +26774769089

PHD SUPERVISORS: Dr Dina Balabanova, Prof Susannah Mayhew

ORGANIZATION: London School of Hygiene and Tropical Medicine & University of Botswana

INFORMED CONSENT

Introduction

Hello, my name is _____ I am PhD student from the London School of Hygiene and Tropical Medicine / I am a carrying out a study on "Understanding and improving the policy process as a critical element to addressing NCDs: the case of Botswana."

I very much value your participation in this study and hope that you will accept to be part of it. Should you have any question or suggestion, now or in the future, please do not hesitate to get in touch directly with one of the principal investigators or the Ministry of Health Ethical Review Committee and the University of Botswana Ethical Review Board.

You will be given a copy of the information sheet and a signed consent form to keep. Thank you for considering taking the time to read this sheet.

Read Information sheet for respondents

Consent Form

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I asked, have been answered to my satisfaction. I consent voluntarily to participate and understand that, I have the right to withdraw from the study at any time without any penalty. I provide permission for my interview to be recorded.

Print Name _____

Signature _____

Date _____ Day/month/year

If the respondent prefers verbal consent: I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____

Signature of witness _____

Date _____Day/month/year

Annex G: Topic guide

NOTE: In its current form, the questionnaire is quite long, but it will be piloted with key respondent groups, before a final focused version (or versions) are produced. There may be a need to develop interview schedules specific to the individual actors to be interviewed, if they can comment on different types of issues – this will be produced after the initial mapping and piloting if deemed necessary. The interview schedules will also be translated into Setswana if required.

Actor Power

This domain refers to the guiding/leading institutions are those playing a stewardship role in the response to NCDs and risk factors.

- Could you please tell me about yourself and your organisation? What are your main areas of work? Tell me a bit more about your work in the area of NCDs.

  PROBES: background & current role & responsibilities – in relation to NCDs

- I was wondering how you came to do what you are doing now regarding NCDs?

  PROBES: Impetus for the idea / Original vision / involvement in the NCDs.

- Could you tell me a bit more about how it all began? The different phases of the NCD policy development if any. What was your role (the role of your organization) in this process?

  PROBES: Reactions / reception / Challenges / Resources available / People involved / supporters

- Could you to tell me about the different actors who were involved in the response to NCDs, both in terms of service delivery and prevention of risk factors?

- What are the leading institutions, those who have power to set agenda and are influential and what is the process through which they shape policy?

- [Donors/Industry: What role do the donors/industry play in the response to NCDs? What about the industry's position relative to the Global Alcohol Framework/ National Alcohol Policy?

- What are the actors' roles in developing policies that underpin the response to NCDs (both for service delivery and prevention)? What are the similarities and differences in these roles?

- What are the different sectors involved in the design and development of the National Strategic Frameworks and policies? How?

  PROBES: e.g. the Medical Insurance Industry? Are they partners?

- If you can compare with the HIV/AIDS response, please comment on the different actors involved in developing policies?

  PROBES: Similarities/differences with NCD? Which are the guiding institutions shaping policies, role of different actors

- What are the mechanisms through which the actors we discussed so far, shape and influence policy?
- How are the responses to NCDs and risk factors coordinated? How are the different actors working together?

  PROBES: Ways of working and interaction, how often do they meet coordination/ lack of coordination, synergies, alignment

- [for NGO/industry: Can you tell us about your relationship with the Ministry of Health. Do they involve you in the response to NCDs, and in what way?]
- To what extent do they follow the global level action plans & declarations recommended for implementation? Please elaborate.
- What are the issues surrounding the governance structure and capacity for NCD and risk factors, including funding for NCDs? How different are these with respect to HIV?
- How involved is the civil society and how are they affected by political circumstances? What about the industry / Alcohol and Tobacco?

  PROBES: Specific coordination issues around contacts between state and non-state actors

- What institutions are seen to be leading policy development and why? What actors are considered to be policy champions (pioneering policies, shaping the debate)?

  PROBES: different views as to who are the leading institutions, who is less involved

- To what extent have the actor roles and involvement in policy development changed over time?

  PROBES: Why, how, due to what factors?

- How are these responses planned and implemented? To what extent did they use the UN Declarations & WHO “Best Buys” Interventions?

  PROBES: Were there more involvement of the global actors? What is their source of power?

- Did these have different sources of power? Did actors become involved over time? How are global and national health policy decision made?

  PROBES: Donor influence, technical support/ funding

Ideas Framing the Issue

This domain refers to the specific activities with respect to ideas framing the issues relevant to the response to NCDs & risk factors.

- Could you please talk about the people's perceptions and views towards NCDs & risk factors in the country. What are the people's views towards the harmful use of alcohol and tobacco?

  PROBES: Are people aware of NCDs and its dangers? Are they manifestations of responsibility and what are their beliefs associated with NCDs and harmful use of alcohol?

- What lessons can be drawn from the framing of HIV?

  PROBES: Stakeholder engagement, participation/ awareness campaigns, public education

- Can you comment on the extent to which global health initiatives, cross national webs of individuals and organizations linked by a shared concern to address a particular health problem global in scope, are reflected in the policy development for NCDs in Botswana?

  PROBES: Are national-level actors working with International Organisations and networks? What is the level of human capital, technical and financial support as in the case with HIV?

Context

This domain refers to the socio-political and economic context within which the actors operate and the windows of opportunity for key actors to influence decision making on the response to NCDs and risk factors.

- To what extent have key actors taken advantage of the policy window created by the UNGASS, WHO "Best Buys", the Alcohol & Tobacco policy in developing National Strategic Frameworks and Policies?

  PROBES: Policy transfers & the extent of the donor influence/ Lobbying by the Alcohol Association

- What lessons can be drawn from the HIV to address the challenges and opportunities?

  PROBES: Multisectoral Approach and stakeholder engagement/ Role the medical insurance

- Are there any external factors and or political forces involved in the NCDs response? How influential are they?

  PROBES: Partnerships and their level of power and influence/ Political climate in the country and the influence of political parties.

- How has the political climate changed overtime and has it had a bearing on the NCDs response? What about international politics?

- What contextual factors that affect the alcohol and tobacco industry have changed? In what way has their role been affected?

  PROBES: Political climate and national political commitment & leadership, influence of international politics on the response to NCDs? What influence do they have as a partner/ adherence to liquor trading hours?

- Are there any significant changes in the Botswana's economic performance that have affected the response to NCDs? How different is it with the response to HIV?

PROBE: development trajectory at different time points, during the HIV/AIDS response and later, income GDP & economic performance, significant variations and economic changes or challenges.

- Could you comment on any cultural perceptions and believes barriers that are acting as a barrier to NCDs response amongst the population?
- If yes, is it the same as it was for HIV? If no, please elaborate.

  PROBES: Medical pluralism for HIV/ NCDs.

Issue Characteristics

This domain refers to the impact of issue characteristics/ for NCD and risk factors response over time examining what has been agreed to as the substance of the policy, including target population or beneficiaries (as embedded in the legislation, policy document, regulations and guidelines incentivized outputs/indicators, management structures etc.).

- What are the perceptions of treatment for NCDs? What lessons can be drawn from HIV?
- How does HIV differ from NCDs? Where are the similarities?

  PROBES: Lessons to be learnt from HIV/Approach / beliefs & perceptions of treatment of NCDs
- What are the individual interests, preferences and values of the population, with implications for the ways policies are framed and developed?

  PROBE: Do they want the status quo to remain/ satisfaction & dissatisfaction/ how
- Please comment on any similarities & differences when comparing policy development for NCDs and HIV/AIDS.

  PROBES: Service delivery/multi sectoral approach/ funding/human/technical resources.

Concluding section

- Given the issues we discussed so far, what are the main constraints for developing policies for NCD?
- What are the opportunities?
- What can be learnt from this process, in your view?
- What lessons can be drawn from HIV/AIDS?
- Do you have any final comments, key things that may explain how NCD policy has evolved?

References

1. UN High Level General Assembly. UNGASS Political Declaration on Non Communicable Diseases. 2011;66th Session Agenda Item 17.
2. Magnusson R, Patterson D. Global action, but national results: strengthening pathways towards better health outcomes for non-communicable diseases. Critical Public Health. 2021;31(4):464-76.
3. World Health Organization. The Political Declaration of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases: commitments of Member States and the way forward. 2012.
4. Mensah GA, Mayosi BM. The 2011 United Nations high-level meeting on non-communicable diseases: the Africa agenda calls for a 5-by-5 approach. SAMJ: South African Medical Journal. 2013;103(2):77-9.
5. Horton R, Sargent J. 2018 must be the year for action against NCDs. The Lancet. 2018;391(10134):1971-3.
6. World Health Organization. Action plan for the prevention and control of noncommunicable diseases in south-east Asia, 2013–2020. World Health Organization. Regional Office for South-East Asia; 2013.
7. Abiona O, Oluwasanu M, Oladepo O. Analysis of alcohol policy in Nigeria: multi-sectoral action and the integration of the WHO "best-buy" interventions. BMC Public Health. 2019;19(1):810.
8. Collins T, Mikkelsen B, Adams J, Chestnov O, Evans T, Feigl A, et al. Addressing NCDs: A unifying agenda for sustainable development. Global public health. 2018;13(9):1152-7.
9. Sridhar D, Morrison JS, Piot P. Getting the politics right for the September 2011 UN high-level meeting on noncommunicable diseases: Center for Strategic and International Studies ^ eWashington DC Washington DC; 2011.
10. Tapela NM, Tshisimogo G, Shatera BP, Letsatsi V, Gaborone M, Madidimalo T, et al. Integrating noncommunicable disease services into primary health care, Botswana. Bulletin of the World Health Organization. 2019;97(2):142.
11. Morriss P. Steven Lukes on the concept of power. Political Studies Review. 2006;4(2):124-35.
12. Sharma KC, Seleke TL. HIV/AIDS in Africa: Botswana's Response to the Pandemic. PUBLIC ADMINISTRATION AND PUBLIC POLICY-NEW YORK-. 2008;138:321.
13. Government of Botswana MB. Chronic Disease Risk Factor Surveillance Report. 2007.
14. Tripathy JP. Partnerships in noncommunicable disease prevention and control. International Journal of Noncommunicable Diseases. 2017;2(4):102-6.
15. Hardon A, Davey S, Gerrits T, Hodgkin C, Irunde H, Kgatlwane J, et al. From access to adherence: the challenges of antiretroviral treatment: studies from Botswana, Tanzania and Uganda 2006: World Health Organization; 2006.
16. Letamo G, Bainame K. The socio-economic and cultural context of the spread of HIV/AIDS in Botswana. Health Transition Review. 1997;7:97-101.
17. Botswana Go. Botswana National Policy on HIV/AIDS. In: Health Mo, editor. The Revised National Policy on HIV/AIDS in Botswana. ed. Gaborone: Government Printer; 2012.
18. Ramogola-Masire D, Poku O, Mazhani L, Ndwapi N, Misra S, Arscott-Mills T, et al. Botswana's HIV response: Policies, context, and future directions. Journal of community psychology. 2020;48(3):1066-70.
19. Hagemann B, Stroope S. Developing the next generation of leaders. Industrial and Commercial Training. 2013;45(2):123-6.
20. World Bank. Economic Review. December 2023; 2023 1st December 2023.
21. Serema BC, editor Community information structures in Botswana: A challenge for librarians. 68th IFLA Council and General Conference; 2002.

22. Bosu WK. A comprehensive review of the policy and programmatic response to chronic non-communicable disease in Ghana. Ghana Med J. 2012;46(2 Suppl):69-78.
23. Masupe T, Mashalla Y, Seloilwe E, Jibril H, Medhin H. Integrated management of HIV/NCDs: knowledge, attitudes, and practices of health care workers in Gaborone, Botswana. African health sciences. 2019;19(3):2312-23.
24. Tapera R, Moseki S, January J. The status of health promotion in Botswana. J Public Health Afr. 2018;9(1):699.
25. Juma PA, Mapa-Tassou C, Mohamed SF, Matanje Mwagomba BL, Ndinda C, Oluwasanu M, et al. Multi-sectoral action in non-communicable disease prevention policy development in five African countries. BMC Public Health. 2018;18(Suppl 1):953.
26. Reid M, Mosepele M, Tsima B, Gross R. Public Health Action. 2012.
27. Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. The lancet. 2007;370(9595):1370-9.
28. UNDP. Botswana National Alcohol Policy. Gaborone: UNDP; 2017.
29. WHO. WHO Noncommunicable Diseases Progress. Geneva, Swirtzerland: WHO; 2020.
30. Ntiyani N, Letamo G, Keetile M. Prevalence of and factors associated with hypertension, diabetes, stroke and heart attack multimorbidity in Botswana: evidence from STEPS 2014 survey. PLoS One. 2022;17(3):e0265722.
31. Reader AM. Health Policy and Systems Research. 2012.
32. Sanni S, Wisdom JP, Ayo-Yusuf OA, Hongoro C. Multi-sectoral approach to noncommunicable disease prevention policy in Sub-Saharan Africa: a conceptual framework for analysis. International Journal of Health Services. 2019;49(2):371-92.
33. Walt G, Gilson L. Can frameworks inform knowledge about health policy processes? Reviewing health policy papers on agenda setting and testing them against a specific priority-setting framework. Health policy and planning. 2014;29(suppl_3):iii6-iii22.
34. Behzadifar M, Gorji HA, Rezapour A, Bragazzi NL. The hepatitis C infection in Iran: a policy analysis of agenda-setting using Kingdon's multiple streams framework. Health research policy and systems. 2019;17:1-10.
35. Kingdon JW, Stano E. Agendas, alternatives, and public policies: Little, Brown Boston; 1984.
36. Mhazo AT, Maponga CC. Agenda setting for essential medicines policy in sub-Saharan Africa: a retrospective policy analysis using Kingdon's multiple streams model. Health Research Policy and Systems. 2021;19(1):72.
37. Snell B, Dualeh M, editors. Proper use of the right drugs: a complex task. World health forum 1988; 9 (2): 207-213; 1988.
38. Cairney P, Jones MD. K ingdon's multiple streams approach: what is the empirical impact of this universal theory? Policy studies journal. 2016;44(1):37-58.
39. Hoefer R. The multiple streams framework: understanding and applying the problems, policies, and politics approach. Journal of Policy Practice and Research. 2022;3(1):1-5.
40. Khodayari-Zarnaq R, Alizadeh G. Cardiovascular diseases preventive policy-making process in Iran: A framework-based policy analysis. World Medical & Health Policy. 2022;14(4):679-97.
41. Buse K, Mays N, Colombini M, Fraser A, Khan M, Walls H. Making Health Policy, 3e: McGraw Hill; 2023.
42. Nugent R, Bertram MY, Jan S, Niessen LW, Sassi F, Jamison DT, et al. Investing in non-communicable disease prevention and management to advance the Sustainable Development Goals. The Lancet. 2018;391(10134):2029-35.
43. Dolowitz DP, Marsh D. Learning from abroad: The role of policy transfer in contemporary policy-making. Governance. 2000;13(1):5-23.
44. Rose R. What is lesson-drawing? Journal of public policy. 1991;11(1):3-30.

45. Flyvbjerg B. Case study. The Sage handbook of qualitative research. 2011;4:301-16.
46. Yin RK. Case study research: Design and methods: sage; 2009.
47. Devi B. Research Methods and Field Work: A Case study Method2014.
48. Solberg Søilen K, Huber S. 20 svenska fallstudier för små och medelstora företag: pedagogik och vetenskaplig metod: Studentlitteratur; 2006.
49. Langlois EV, Becerril Montekio V, Young T, Song K, Alcalde-Rabanal J, Tran N. Enhancing evidence informed policymaking in complex health systems: lessons from multi-site collaborative approaches. Health Res Policy Syst. 2016;14:20.
50. Tellis W. Introduction to case study. The qualitative report. 1997;3(2):1-14.
51. Zainal Z. A Case Study as a Research Method. Journal Kemanusiaan 2007;bil 19.
52. Gichuna S HR, Sanders T et al. Access to Health Care in a time of COVID-19: Sex workers in crisis in Nairobi/Kenya. Global public health. 20201;15, .
53. Lim WM. What is qualitative research? An overview and guidelines. Australasian Marketing Journal. 2024:14413582241264619.
54. Cronin C. Using case study research as a rigorous form of inquiry. Nurse researcher. 2014;21(5).
55. Lindvall J. Fallstudiestrategier. Statsvetenskaplig tidskrift. 2007;109(3).
56. Stake RE. The case study method in social inquiry. Educational researcher. 1978;7(2):5-8.
57. Jacobsen DI, Sandin G, Hellström C. Vad, hur och varför: om metodval i företagsekonomi och andra samhällsvetenskapliga ämnen: Studentlitteratur AB; 2002.
58. Merriam SB. Qualitative research: A guide to design and implementation. Jossey-Bass; 2009.
59. Cope DG. Case study research methodology in nursing research. Number 6/November 2015. 2015;42(6):681-2.
60. Krusenvik L. Using case studies as a scientific method: Advantages and disadvantages. 2016.
61. Siggelkow N. Persuasion with case studies. Academy of management journal. 2007;50(1):20-4.
62. Hammersley M. Troubling theory in case study research. Higher education research & development. 2012;31(3):393-405.
63. Soy S. The case study as a research method. 2015.
64. Abrami PC, Cohen PA, d'Apollonia S. Implementation problems in meta-analysis. Review of Educational Research. 1988;58(2):151-79.
65. Bernier NF, Clavier C. Public health policy research: making the case for a political science approach. Health promotion international. 2011;26(1):109-16.
66. Robey RR, Dalebout SD. A tutorial on conducting meta-analyses of clinical outcome research. Journal of Speech, Language, and Hearing Research. 1998;41(6):1227-41.
67. World Health Organization. Global action plan for the prevention and control of noncommunicable diseases 2013-2020: World Health Organization; 2013.
68. Shiroya V, Neuhann F, Muller O, Deckert A. Challenges in policy reforms for non-communicable diseases: the case of diabetes in Kenya. Glob Health Action. 2019;12(1):1611243.
69. Van Walbeek C. Tobacco control in South Africa. Promotion & Education. 2005:25-8, 57.
70. Essue BM, Kapiriri L. The unfunded priorities: an evaluation of priority setting for noncommunicable disease control in Uganda. Global Health. 2018;14(1):22.
71. Wickramasinghe K, Wilkins E, Foster C, Fadhil I, Hammerich A, Slama S, et al. The development of national multisectoral action plans for the prevention and control of noncommunicable diseases: experiences of national-level stakeholders in four countries. Glob Health Action. 2018;11(1):1532632.
72. Lupafya PC, Mwagomba BL, Hosig K, Maseko LM, Chimbali H. Implementation of Policies and Strategies for Control of Noncommunicable Diseases in Malawi: Challenges and Opportunities. Health Educ Behav. 2016;43(1 Suppl):64s-9s.

73. Nyaaba GN, Stronks K, de-Graft Aikins A, Kengne AP, Agyemang C. Tracing Africa's progress towards implementing the Non-Communicable Diseases Global action plan 2013-2020: a synthesis of WHO country profile reports. BMC Public Health. 2017;17(1):297.
74. Juma PA, Mohamed SF, Matanje Mwagomba BL, Ndinda C, Mapa-Tassou C, Oluwasanu M, et al. Non-communicable disease prevention policy process in five African countries. BMC Public Health. 2018;18(Suppl 1):961.
75. World Health Organization. Tackling NCDs:'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. World Health Organization; 2017.
76. Matanje Mwagomba BL, Nkhata MJ, Baldacchino A, Wisdom J, Ngwira B. Alcohol policies in Malawi: inclusion of WHO "best buy" interventions and use of multi-sectoral action. BMC Public Health. 2018;18(Suppl 1):957.
77. World Health Organization. Noncommunicable diseases country profiles 2018. 2018.
78. Mapa-Tassou C, Bonono CR, Assah F, Wisdom J, Juma PA, Katte JC, et al. Two decades of tobacco use prevention and control policies in Cameroon: results from the analysis of non-communicable disease prevention policies in Africa. BMC Public Health. 2018;18(Suppl 1):958.
79. Daivadanam M, Ingram M, Sidney Annerstedt K, Parker G, Bobrow K, Dolovich L, et al. The role of context in implementation research for non-communicable diseases: Answering the 'how-to' dilemma. PLoS One. 2019;14(4):e0214454.
80. Schwartz JI, Guwatudde D, Nugent R, Kiiza CM. Looking at non-communicable diseases in Uganda through a local lens: an analysis using locally derived data. Global Health. 2014;10:77.
81. UN General Assembly. Transforming our world: the 2030 Agenda for sustainable development. Resolution adopted by the general assembly on 25 September 2015. New York: United Nations; 2015. 2015.
82. Wisdom JP, Juma P, Mwagomba B, Ndinda C, Mapa-Tassou C, Assah F, et al. Influence of the WHO framework convention on tobacco control on tobacco legislation and policies in sub-Saharan Africa. BMC Public Health. 2018;18:1-10.
83. Bekker L-G, Alleyne G, Baral S, Cepeda J, Daskalakis D, Dowdy D, et al. Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society—Lancet Commission. The Lancet. 2018;392(10144):312-58.
84. Achwoka D, Waruru A, Chen T-H, Masamaro K, Ngugi E, Kimani M, et al. Noncommunicable disease burden among HIV patients in care: a national retrospective longitudinal analysis of HIV-treatment outcomes in Kenya, 2003-2013. BMC public health. 2019;19(1):1-10.
85. Mocumbi AO. Focus on non-communicable diseases: an important agenda for the African continent. Cardiovasc Diagn Ther. 2013;3(4):193-5.
86. Metta E, Msambichaka B, Mwangome M, Nyato DJ, Dieleman M, Haisma H, et al. Public policy, health system, and community actions against illness as platforms for response to NCDs in Tanzania: a narrative review. Glob Health Action. 2014;7:23439.
87. Ferreira-Borges C, Parry CD, Babor TF. Harmful use of alcohol: a shadow over sub-Saharan Africa in need of workable solutions. International journal of environmental research and public health. 2017;14(4):346.
88. Meline T. Selecting studies for systemic review: Inclusion and exclusion criteria. Contemporary issues in communication science and disorders. 2006;33(Spring):21-7.
89. Organization WH. Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases: World Health Organization; 2024.
90. Payyappallimana U, Fadeeva Z. Ensure Healthy Lives and Promote Well-being for All: Experiences of community health, hygiene, sanitation and nutrition. 2018.
91. Bhatia T, Nakamura R, Shichijo A. 4. Best Buys. 2019.
92. Thomas DJ. Public Health: Profit motive. State inaction dictate outcomes2021 11th January 2025.

93. Mukanu MM, Zulu JM, Mweemba C, Mutale W. Responding to non-communicable diseases in Zambia: a policy analysis. Health Res Policy Syst. 2017;15(1):34.
94. Erkoc Y, Yardım N. Policies for tackling non-communicable diseases and risk factors in Turkey. Republic of Turkey Ministry of Health, Directorate General Primary Health Care: Ankara. 2011.
95. Kickbusch I, Allen L, Franz C. The commercial determinants of health. The Lancet Global Health. 2016;4(12):e895-e6.
96. Maani N, Petticrew M, Galea S. The commercial determinants of health: Oxford University Press; 2023.
97. Loffreda G, Arakelyan S, Bou-Orm I, Holmer H, Allen LN, Witter S, et al. Barriers and Opportunities for WHO 'Best Buys' Non-Communicable Disease Policy Adoption and Implementation From a Political Economy Perspective: A Complexity Systematic Review. International Journal of Health Policy and Management. 2024;13.
98. Shiell A, Hawe P, Gold L. Complex interventions or complex systems? Implications for health economic evaluation. Bmj. 2008;336(7656):1281-3.
99. Allen LN, Pullar J, Wickramasinghe KK, Williams J, Roberts N, Mikkelsen B, et al. Evaluation of research on interventions aligned to WHO 'Best Buys' for NCDs in low-income and lower-middle-income countries: a systematic review from 1990 to 2015. BMJ global health. 2018;3(1):e000535.
100. Jakovljevic M, Jakab M, Gerdtham U, McDaid D, Ogura S, Varavikova E, et al. Comparative financing analysis and political economy of noncommunicable diseases. Journal of medical economics. 2019;22(8):722-7.
101. Dye TR. Understanding public policy. (No Title). 1992.
102. Unwin N, Mugusi F, Aspray T, Whiting D, Edwards R, Mbanya JC, et al. Tackling the emerging pandemic of non-communicable diseases in sub-Saharan Africa: the essential NCD health intervention project. Public Health. 1999;113(3):141-6.
103. Minichiello V, Aroni R, Hays TN. In-depth interviewing: Principles, techniques, analysis: Pearson Education Australia; 2008.
104. Welsh E, editor Dealing with data: Using NVivo in the qualitative data analysis process. Forum qualitative sozialforschung/Forum: qualitative social research; 2002.
105. Bowen GA. Document analysis as a qualitative research method. Qualitative research journal. 2009;9(2):27-40.
106. Bakke Ø, Endal D. Vested interests in addiction research and policy alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. Addiction. 2010;105(1):22-8.
107. WHO. Monitoring The Building Blocks of Health Systems: A handbook of indicators and their measurement strategies. Geneva, Swirtzerland: World Health Organisation; 2010.
108. Botswana USEi. PEPFAR in Botswana. United States of America Embassy in Botswana; 2015.
109. Lakon CM, Wang C, Butts CT, Jose R, Timberlake DS, Hipp JR. A dynamic model of adolescent friendship networks, parental influences, and smoking. Journal of youth and adolescence. 2015;44:1767-86.
110. Tapera R, Mbongwe B, Mhaka-Mutepfa M, Lord A, Phaladze NA, Zetola NM. The theory of planned behavior as a behavior change model for tobacco control strategies among adolescents in Botswana. PloS one. 2020;15(6):e0233462.
111. Mmegi. Botswana Slashes alcohol levy to attract investors2019.
112. Christiansson Y & Larsson J. HIV/AIDS in Botswana - A matter of governance. 2007.
113. Pastakia SD, Pekny CR, Manyara SM, Fischer L. Diabetes in sub-Saharan Africa–from policy to practice to progress: targeting the existing gaps for future care for diabetes. Diabetes, metabolic syndrome and obesity: targets and therapy. 2017:247-63.

114. Beaglehole R, Yach D. Globalisation and the prevention and control of non-communicable disease: the neglected chronic diseases of adults. The lancet. 2003;362(9387):903-8.
115. Silva-Matos C, Beran D. Non-communicable diseases in Mozambique: risk factors, burden, response and outcomes to date. Globalization and health. 2012;8:1-10.
116. Islam A, Biswas T. Health system in Bangladesh: challenges and opportunities. American Journal of Health Research. 2014;2(6):366-74.
117. Al-Bahlani S, Mabry R. Preventing non-communicable disease in Oman, a legislative review. Health promotion international. 2014;29(suppl_1):i83-i91.
118. Meghani A, Ssemugabo C, Pariyo G, Hyder AA, Rutebemberwa E, Gibson DG. Curbing the rise of noncommunicable diseases in Uganda: perspectives of policy actors. Global Health: Science and Practice. 2021;9(1):149-59.
119. Khan MS, Meghani A, Liverani M, Roychowdhury I, Parkhurst J. How do external donors influence national health policy processes? Experiences of domestic policy actors in Cambodia and Pakistan. Health policy and planning. 2018;33(2):215-23.
120. Parkhurst J. The politics of evidence: from evidence-based policy to the good governance of evidence: Taylor & Francis; 2017.
121. Alwan A, MacLean DR, Riley LM, d'Espaignet ET, Mathers CD, Stevens GA, et al. Monitoring and surveillance of chronic non-communicable diseases: progress and capacity in high-burden countries. The Lancet. 2010;376(9755):1861-8.
122. World Health Organization. Multisectoral coordination mechanisms and responses to noncommunicable diseases in South-East Asia: Where are we in 2018? 2019.
123. Rani M, Nusrat S, Hawken LH. A qualitative study of governance of evolving response to non-communicable diseases in low-and middle-income countries: current status, risks and options. BMC Public Health. 2012;12:1-13.
124. McKee M, Haines A, Ebrahim S, Lamptey P, Barreto ML, Matheson D, et al. Towards a comprehensive global approach to prevention and control of NCDs. Globalization and health. 2014;10:1-7.
125. Pearce N, Ebrahim S, McKee M, Lamptey P, Barreto ML, Matheson D, et al. The road to 25× 25: how can the five-target strategy reach its goal? The Lancet Global Health. 2014;2(3):e126-e8.
126. World Health Organization. Regional Office for E. Declaration of Alma-Ata. Copenhagen: World Health Organization. Regional Office for Europe; 1978 1978. Contract No: WHO/EURO. 1978:3938-43697.
127. World Health Organization. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. World Health Organization; 2018.
128. Haque M, Islam T, Rahman NAA, McKimm J, Abdullah A, Dhingra S. Strengthening primary health-care services to help prevent and control long-term (chronic) non-communicable diseases in low-and middle-income countries. Risk management and healthcare policy. 2020:409-26.
129. Le Roux SR, Jassat W, Dickson L, Mitrani L, Cox H, Mlisana K, et al. The role of emergent champions in policy implementation for decentralised drug-resistant tuberculosis care in South Africa. BMJ global health. 2022;7(12):e008907.
130. Powell BJ, Waltz TJ, Chinman MJ, Damschroder LJ, Smith JL, Matthieu MM, et al. A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. Implementation science. 2015;10:1-14.
131. Cassim A. What happens to policy when policy champions move on? The case of welfare in South Africa. Brighton: Institute of Development Studies. 2016.
132. Faraji F, Shojaei L. Risk factors and National Response to Diabetes in Selected Countries: A comparative study. Journal of Diabetes Nursing. 2022;10(1):1769-82.
133. Alliance N. Advocacy agenda for people living with NCDs. Geneva: Author; 2017.

134. Odoch WD, Kabali K, Ankunda R, Zulu JM, Tetui M. Introduction of male circumcision for HIV prevention in Uganda: analysis of the policy process. Health research policy and systems. 2015;13:1-13.
135. Atun R, Jaffar S, Nishtar S, Knaul FM, Barreto ML, Nyirenda M, et al. Improving responsiveness of health systems to non-communicable diseases. The Lancet. 2013;381(9867):690-7.
136. Lunze K, Migliorini L. Tobacco control in the Russian Federation-a policy analysis. BMC public health. 2013;13:1-11.
137. Hutchinson AD, Wilson C. Improving nutrition and physical activity in the workplace: a meta-analysis of intervention studies. Health promotion international. 2012;27(2):238-49.
138. Santos WJ, Graham ID, Lalonde M, Demery Varin M, Squires JE. The effectiveness of champions in implementing innovations in health care: a systematic review. Implementation Science Communications. 2022;3(1):80.
139. Anderson P, Cremona A, Paton A, Turner C, Wallace P. The risk of alcohol. Addiction. 1993;88(11):1493-508.
140. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. The lancet. 2010;376(9748):1261-71.
141. Schelleman-Offermans K, Knibbe RA, Kuntsche E, Casswell S. Effects of a natural community intervention intensifying alcohol law enforcement combined with a restrictive alcohol policy on adolescent alcohol use. Journal of Adolescent Health. 2012;51(6):580-7.
142. Spoth R, Greenberg M, Turrisi R. Overview of preventive interventions addressing underage drinking: State of the evidence and steps toward public health impact. Alcohol Research & Health. 2009;32(1):53.
143. Allen L. Why is there no funding for non-communicable diseases? Journal of Global Health Perspectives. 2016.
144. Mahajan M. The IHME in the shifting landscape of global health metrics. Global policy. 2019;10:110-20.
145. Meghani A, Basu S. A review of innovative international financing mechanisms to address noncommunicable diseases. Health Affairs. 2015;34(9):1546-53.
146. Seleke TL, Mokaloba M. Has Donor Funding Been Able to Change the HIV/AIDS Policy Agenda in Botswana? Botswana Notes and Records. 2018;50:166-77.
147. Jailobaeva K, Falconer J, Loffreda G, Arakelyan S, Witter S, Ager A. An analysis of policy and funding priorities of global actors regarding noncommunicable disease in low-and middle-income countries. Globalization and health. 2021;17:1-15.
148. Nabyonga-Orem J, Ssengooba F, Macq J, Criel B. Malaria treatment policy change in Uganda: what role did evidence play? Malaria journal. 2014;13:1-17.
149. Buse K, Mays N, Walt G. Understanding public health. Making health policy. 2005:288.
150. Colombini M, Mayhew SH, Lund R, Singh N, Swahnberg K, Infanti J, et al. Factors shaping political priorities for violence against women-mitigation policies in Sri Lanka. BMC international health and human rights. 2018;18:1-12.