Competing Pressures for U.S. PEPFAR in Botswana
RISING AMBITIONS, DECLINING RESOURCES

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Authors
Sharon Stash
Jennifer Cooke
Matt Fisher
Alisha Kramer
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Sharon Stash, Jennifer Cooke, Matt Fisher, and Alisha Kramer

Executive Summary

Botswana has made tremendous strides in the fight against HIV/AIDS in the last decade, supported by the early and important U.S. partnership created through the President’s Emergency Plan for AIDS Relief (PEPFAR).

In the next five years, however, that partnership will be tested as the United States and Botswana negotiate a complex, multiyear handoff of PEPFAR-supported HIV/AIDS activities and as U.S. financial assistance is reduced. U.S. funding through PEPFAR is anticipated to decrease from $75 million to a plateau of $35 million by 2016, with an annual reduction in funding of about $10 million per year.2

Yet, as pressure mounts for PEPFAR in Botswana to transition, the Obama administration has stepped up expectations for all partner governments through its call for the creation of an “AIDS-free Generation,” in which virtually no children are born with the HIV virus; where teenagers and adults are at far lower risk of becoming infected; and where, if they do acquire HIV, they have access to treatment that helps prevent them from developing AIDS and passing the virus on to others.

1 Sharon Stash is a senior fellow and deputy director of the CSIS Global Health Policy Center. Jennifer Cooke is director of the CSIS Africa Program. Matt Fisher is a project coordinator and research assistant with the CSIS Global Health Policy Center. Alisha Kramer is a program coordinator and research assistant with the CSIS Global Health Policy Center. The authors owe a debt of gratitude to the leadership and staff at the U.S. embassy in Gaborone, the U.S. Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC). A particular note of thanks to Ambassador Michelle Gavin, CDC country director Kathleen Toomey, USAID country director Joan LaRosa, Drew Voetsch and Mary Glenshaw of CDC, and John Moreti of the Botswana Office of the President. Many stakeholders also provided valuable input that contributed to the development of this document, including Bamalete Lutheran Hospital, Baylor International Pediatric AIDS Initiative, I-Tech, Bontleng Clinic, Botswana Harvard AIDS Institute, Botswana Ministry of Health, Crown Agents and SCMS, Econsult, FHI360, Futures Group, National AIDS Coordinating Agency, Nkaikela Youth Group, Nkyophiri Clinic, Princess Marina Hospital, Project Concern International, Research Triangle Institute, Tshelopo, UNAIDS, and the World Health Organization (WHO).

2 PEPFAR/Botswana, personal communications.
Over the past 10 years, Botswana has proved itself a willing and capable PEPFAR partner, and it is among the most promising nations in Africa for achieving these ambitious goals. Botswana’s national program already provides universal access to HIV treatment and prevents most HIV-positive mothers from transmitting the virus to their babies. Yet, as is typical of PEPFAR countries in southern Africa, Botswana also has considerable work to do to prevent new HIV infections. Currently, one of every four adults age 15 to 49 in Botswana is infected with HIV. As such, Botswana is a good setting in which to see whether an AIDS-free Generation is achievable and to better understand what success might require in terms of policy and programmatic innovations, health planning and management capacity, and costs.

To explore the opportunities and challenges ahead, a small team from the CSIS Global Health Policy Center traveled to Gaborone and surrounding areas in August 2012 for an intensive series of interviews with U.S. embassy and government agencies, officials from the government of Botswana, implementers, economists, and health researchers.

The CSIS team concluded that progress toward an AIDS-free Generation is achievable in Botswana, even in the context of reduced U.S. support, but success will depend on U.S. leadership and action in five key areas:

1. Negotiating and communicating priorities
2. Accelerating prevention
3. Increasing community ownership and engagement
4. Investing in health planning and management capacity
5. Continuing investments in a robust research agenda

Creating an AIDS-free Generation

The goal of creating an AIDS-free Generation emerged from new enthusiasm engendered by scientific findings, many of which emerged during the last two or three years. After years of disappointing results, the advent of several efficacious interventions has reinvigorated the field of HIV prevention. Strong evidence now supports the protective effects of circumcision for men, and a growing body of evidence supports the use of antiretroviral drugs in HIV-positive people to reduce transmission of the virus from mother to child and to sexual partners.

Capitalizing on momentum created by these findings, in her November 2011 address to the U.S. National Institutes of Health, Secretary of State Hillary Clinton communicated an ambitious vision for an AIDS-free Generation: “[O]ur efforts have helped set the stage for a historic opportunity, one that the world has today: to change the course of this pandemic and usher in an AIDS-free

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Generation.” An AIDS-free Generation was defined as a generation in which virtually no children are born with the virus; where teenagers and adults are at far lower risk of becoming infected; and where, if they do acquire HIV, they have access to treatment that helps prevent them from developing AIDS and passing the virus on to others.4

Momentum continued to build throughout 2012. President Barack Obama reinforced the vision of an AIDS-free Generation on World AIDS Day in December 2011 and set new targets for the U.S. government: to help 6 million people around the world get treatment by the end of 2013 (an increase of 2 million from the U.S. government’s original goal); and to provide antiretroviral drugs to more than 1.5 million HIV-positive women to prevent mother-to-child transmission.5 When the International AIDS Society meeting returned to the United States for the first time in nearly a quarter of a century this summer, Secretary Clinton pledged an additional $80 million of support for HIV/AIDS stating, “The United States is committed and will remain committed to achieving an AIDS-free Generation. We will not back off. We will not back down. We will fight for the resources necessary to achieve this historic milestone.”6

But for all the excitement, the AIDS-free Generation challenge also raised key questions. Throughout 2012, global health experts and PEPFAR agencies struggled to gain a clearer understanding of the concept and its implications. There is an ongoing effort in the HIV/AIDS community to more clearly articulate key definitions, and important issues remain at play. These struggles will crescendo in December 2012, when the Office of the Global AIDS Coordinator (OGAC) is slated to produce a blueprint for an AIDS-free Generation. The document will detail a strategic outline with major goals, challenges, and implementation steps.

Some question the endpoint that is implied. Although an AIDS-free Generation calls for the end of AIDS—the syndrome that occurs as the result of infection with the HIV virus—it stops short of calling for the end of HIV viral infections. The virus has proven itself a formidable foe, and scientific leaders maintain that new infections cannot be fully limited in the absence of more effective prevention tools, especially a vaccine.7

Others question the target audience. The goals of an AIDS-free Generation focus explicitly on the health and welfare of young people, for whom there is promising evidence of declines in HIV

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prevalence in Botswana. Evidence from two national surveys conducted in 2004 and 2008 indicates that HIV prevalence declined from 6.6 to 3.7 percent among persons 15 to 19 years of age and from 19 to 12 percent among persons aged 20 to 24 years. Public health practitioners must now focus on keeping young people free of AIDS in the long run for fear that they may avoid acquiring HIV in their youth only to become infected at later ages. Moreover, HIV prevalence among older people will almost certainly continue to rise for several years, because of continued new HIV infections and increased survivorship as more people benefit from treatment.

Finally, there is active debate in the international AIDS community around the approach OGAC is promoting to achieve prevention goals. In accordance with general directions set by multilateral organizations, the Obama administration has placed a strategic bet on “combination prevention.” Proponents of this approach hold that, since no single HIV-prevention strategy will be sufficient to control the HIV pandemic, programs should implement packages of interventions that have shown promise in partially protecting against HIV. Over the last two years, OGAC has gone to great lengths to review the scientific evidence and to determine which HIV-prevention interventions are most effective. As a result, the U.S. government’s definition of combination prevention places special emphasis on three core interventions, including expanding voluntary medical male circumcision (VMMC), stopping the transmission of HIV from mothers to children, and treatment with antiretroviral drugs (ARVs) in HIV-positive people to reduce risk of transmission. Although, the approach also recognizes that these core interventions will work best when combined with condoms, counseling and testing, and other effective prevention interventions for high-risk populations.

Some experts argue that the combination prevention approach recommended by OGAC focuses too narrowly on biomedical interventions and that more emphasis should be placed on interventions designed to change people’s sexual behaviors and lower their risk of acquiring HIV. Although once a mainstay of HIV-prevention programs, recent studies suggest that these approaches to changing

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8 Usually given as a percentage, HIV prevalence quantifies the proportion of individuals in a population who are living with HIV at a specific point in time.
10 The Office of the U.S. Global AIDS Coordinator (OGAC) leads implementation of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).
individuals’ sexual behaviors may have little overall impact on the transmission of HIV.\textsuperscript{13} While the debate continues, OGAC guidance recommends that U.S. government agencies limit their funding of large-scale behavior change interventions, although some programs will be implemented on a smaller scale with accompanying evaluations.\textsuperscript{14} Moreover, U.S. government agencies are working with local organizations that implement HIV-prevention activities to modify what they do and how they work. These changes do not come easy, and since PEPFAR’s recommendations are fairly recent, they have not yet been fully implemented.

Finally, a note of caution is in order, since the overall impact of the combination prevention approach on the ground, where it counts from a public health perspective, remains unknown. PEPFAR has funded a series of combination prevention trials,\textsuperscript{15} one of which is currently being conducted in Botswana with CDC support.\textsuperscript{16} Additional efforts are underway to model the impact of partially effective biomedical prevention options under different scenarios.

These efforts may ultimately allow U.S. agencies to move beyond counterproductive dichotomies that currently exist between behavioral and biomedical interventions and clarify how the United States and governments throughout the world can invest in the most effective mix of prevention services.

The Botswana PEPFAR Partnership

Just one decade ago, with nearly 40 percent of all adults infected with HIV, Botswana’s future appeared bleak.\textsuperscript{17}

Yet, beginning about 10 years ago, robust leadership and advocacy from the highest levels of Botswana’s government increased national expenditures on HIV and catalyzed powerful technical and financial support from private-sector partners, including major grants from the Bill & Melinda Gates and Merck Company Foundations. These investments in turn laid the basis for a major U.S. commitment to Botswana through the President’s Emergency Plan for AIDS Relief (PEPFAR), a


\textsuperscript{14} PEPFAR, ”Technical Considerations Provided by PEPFAR Technical Working Groups for FY 2013 COPS and ROPS,” October 2012.

\textsuperscript{15} In 2009, the National Institutes of Health (NIH) launched a research initiative called the Methods of Prevention Package Program (MP3) to fund combination HIV-prevention studies. The purpose of these grants is to devise optimal HIV-prevention packages for specific populations and to design evaluation strategies to rigorously examine the acceptability, safety, and efficacy of those packages.


cumulative investment of about $650 million over 10 years—remarkable in a country of just over 2 million people.\textsuperscript{18}

These efforts produced notable successes. Botswana today provides antiretroviral therapy (ART) to about 93 percent of eligible individuals and by 2010 had reduced mother-to-child transmission to less than 4 percent, from levels of 30 to 40 percent about 10 years earlier.\textsuperscript{19}

Yet, important challenges remain to reduce the numbers of new HIV infections. Although data show a decline in HIV rates among young people, the rates remain far too high; national surveillance surveys estimate that 10 percent of pregnant women age 15 to 19 are HIV positive and 19 percent of women age 20 to 24 are HIV positive.\textsuperscript{20} Creating an AIDS-free Generation requires that far fewer young people acquire the HIV virus as they age and that those who do are prevented from developing AIDS and live longer and healthier lives through treatment. Ensuring the long-term health of these promising young people is at the heart of creating an AIDS-free Generation.

\textbf{An Uncertain Road Ahead}

Today, the U.S. PEPFAR program in Botswana confronts two competing pressures.

First, the United States and Botswana share rising ambitions in the fight against HIV/AIDS. In 1997, a Presidential Task Group under then-President Festus Mogae drafted a vision statement for Botswana 50 years after independence,\textsuperscript{21} which called, among other goals, for substantial progress toward zero new HIV infections. The U.S. government’s vision for an AIDS-free Generation, outlined in major policy speeches by both President Obama and Secretary of State Clinton,\textsuperscript{22} aligns well with Botswana’s goal.

Yet these bold aspirations come up quickly against the stark realities of cost and the opposing pressure for the U.S. administration to scale down its financial commitments and transition Botswana to a situation in which HIV services are country led and increasingly country financed. When PEPFAR was reauthorized in 2008, the scope of the U.S. program shifted from an emergency response to that of building and sustaining health outcomes and systems through a closer alignment with host country priorities. Botswana’s PEPFAR program is expected to transition quickly and demonstrate to potential skeptics in Congress that PEPFAR partnerships are not open-ended commitments and can be successfully downscaled. PEPFAR support is slated to decline along a

\textsuperscript{18} PEFAR/Botswana, personal communications.
\textsuperscript{22} Clinton, “Remarks on Creating an AIDS-free Generation.”
predetermined “glide path” in which annual funding through PEPFAR decreases from about $75 million to a plateau of $35 million by 2016, with an annual reduction in funding of about $10 million per year.\textsuperscript{23}

As such, Botswana is a promising transition test case: it is a relatively wealthy PEPFAR partner, with the fifth-highest GDP per capita in Africa; the government already shoulders around 70 percent of HIV-related costs;\textsuperscript{24} and U.S. investments, from both public- and private-sector sources, have been substantial for Botswana’s small population of 2 million. As PEPFAR looks to transition South Africa and Namibia as well, there is a strong incentive to demonstrate that it is possible to expedite a transition in Botswana.

Yet, during its August 2012 visit, the message the CSIS team heard loud and clear was “not so fast.” Many of those interviewed were deeply concerned about transitioning Botswana to a more streamlined and strategic engagement, where direct funding declines progressively, and where the United States continues to provide targeted technical support. Many fear that too hasty or inflexible a scale-down of PEPFAR funding in Botswana will make achievement of an AIDS-free Generation less likely and put at risk many of the gains made during the last decade in HIV treatment and prevention of mother-to-child transmission.

**The Challenges of Transition**

PEPFAR’s transition to a less costly and more focused investment in Botswana will require overcoming challenges in at least five major areas.

1. **Covering and containing costs.** While the U.S. government provides only 20 percent of total HIV expenditures,\textsuperscript{25} the decrease in PEPFAR support, said many, comes at a difficult time. The government of Botswana already has a massive public health payroll burden and spends what one U.S. official called a “jaw-dropping” amount on HIV/AIDS—estimated to be about 3.5 percent of GDP in 2010.\textsuperscript{26} Botswana’s recent move to the more inclusive World Health Organization (WHO)–recommended treatment eligibility guidelines adds substantially to the growing number on treatment at the same time that demand for more expensive second- and third-line treatment (i.e., drugs that are given when initial treatments do not work or stop working) is increasing.

The expanded HIV-prevention approach recommended for creating an AIDS-free Generation promises to substantially lower costs in the long term, as far fewer people ultimately require

\textsuperscript{23} PEPFAR/Botswana, personal communications.
\textsuperscript{24} Botswana National AIDS Coordinating Agency, personal communications.
\textsuperscript{25} PEPFAR/Botswana, personal communications.
treatment, but it will increase costs in the short term. Currently, declining donor support and the aftermath of the 2009 economic downturn are forcing politically difficult trade-offs, and according to many of those interviewed, the government’s strategy and willingness to make hard choices remain unclear.

2. Increasing urgency and action around prevention. Despite a history of strong governmental support for HIV/AIDS programs in Botswana, HIV prevention currently receives far too little government or public attention, although it remains the top priority for U.S. foreign assistance to that country. The national discourse around HIV prevention is currently quite limited, and neither the legislature nor the political leadership has made prevention a visible and consistent public priority. A member of a youth club for HIV-positive teens in Gaborone told the CSIS team that among her school peers (and many teachers), stigma around HIV remains high, and knowledge, discussion, and concern around HIV prevention remains disturbingly low.

The United States should engage with the government of Botswana to elevate the urgency around HIV prevention to overcome continued complacency. To do so, the U.S. government will need to provide clear and consistent guidance to partner countries, which is itself complicated by ongoing, vigorous debates in the HIV community. Whereas there is an emerging global consensus that programs should seek ways to support prevention interventions that are effective in reducing HIV infections, and to trim back those that are less effective, U.S. government agencies disagree over what combination of activities constitutes “effective” HIV prevention.

In Botswana, PEPFAR has defunded stand-alone behavior change interventions, and with high-functioning treatment and prevention of mother-to-child transmission programs already in place, the U.S. program has placed considerable faith in the expansion of voluntary medical male circumcision as a tool to drive down rates of new infection. Uptake of male circumcision services, however, has been slower than anticipated, with less than 20 percent of the target population circumcised in 2012 (up 9 percent from a baseline circumcision rate of 11 percent). For many, it is clear that success will also require that Botswana’s local communities give higher priority to HIV prevention and demand and utilize services, for example male circumcision, and that behavioral interventions remain essential to enable communities to achieve that goal.

3. Recruitment and retention of health professionals. Currently, PEPFAR supports personnel secondments of around 150 people to Botswana’s HIV/AIDS agencies, down from a 170-person high-water mark a couple of years ago. Among those on loan are key personnel in planning and strategic information. The majority of these positions are slated to lose U.S. government funding in the next few years, even as, in response to continued pressure from the International

28 OGAC, personal communications.
Monetary Fund, Botswana has implemented a government-wide hiring freeze, which may mean that a majority of these positions go unfilled.

In addition, staff turnover in health facilities is very high and many positions are filled with temporary foreign workers. Although not part of its original plan, PEPFAR has supported training of providers by international nongovernmental organizations on a nearly annual basis to keep up with demand. As the work of international implementing partners is scaled down, Botswana’s public- and private-sector organizations will need to plan very carefully to cover essential functions—for example, procurement and supply chain management.

4. **Fostering community engagement through nongovernmental organizations.** Botswana’s HIV response is overwhelmingly reliant on the public sector, leaving health facility personnel to cover functions that experience has shown can be better done, and at lower cost, by nongovernmental and community-based organizations. At one site the CSIS team visited, doctors themselves were responsible for conducting community outreach and mobilization for male circumcision—an inefficient use of highly trained personnel to perform a task that may be more effectively accomplished by local organizations who understand the community’s perspectives and concerns.

In fact, advancing the goals of an AIDS-free Generation likely rests on Botswana’s ability to amplify and facilitate prevention services at the community level—that is, to increase the urgency around HIV prevention, build support and drive demand for new HIV services such as male circumcision, target underserved populations, and provide ongoing care and support for people living with HIV. Some fear that nongovernmental organizations are not currently capable of fulfilling these roles and that program efforts to strengthen civil society organizations would take too long and be too costly, which rings true given the current graduation schedule.

Moreover, as national HIV/AIDS budgets tighten, there may be a tendency to avoid investments in community-based and nongovernmental organizations and to assume that health providers and health facilities can serve these functions. This could be a costly mistake in a country that already faces challenges in increasing people’s demand for prevention services.

5. **Strengthening health planning and management.** By all reports, the Ministry of Health and the National AIDS Coordinating Agency struggle with management inefficiencies at all levels: within offices responsible for strategic and operation planning; hospitals, clinics, and laboratories; and among nongovernmental organizations. Leadership positions in the Ministry of Health and the National AIDS Coordinating Agency are not always filled with people who have skills in health planning and management, posing additional challenges as Botswana faces difficult trade-offs: “Whatever little you leave behind,” said one official in the Ministry of Health, “focus on helping us spend our own money better.”

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The health sector’s centralization has reinforced a tendency toward top-down directives and supply-driven provision of equipment, personnel, and medications to health facilities. With little authority to make decisions about resource allocation, staff incentives, or procurement, hospitals and clinics fail to operate at maximal efficiency, and both staff and management are often demoralized and unmotivated.

A variety of bilateral and other donors have tried to improve Botswana’s capacity to manage various aspects of the HIV/AIDS response. Some investments in strengthening health systems have begun to pay off; for example, PEPFAR’s investments in improving procurement and strengthening the supply chain have yielded important results, resulting in fewer stock-outs of medicines and medical supplies. But some fear that the government is not adequately prepared to take over these “mission-critical” functions.
Managing Transition

PEPFAR’s transition itself will need to be strategically negotiated, communicated, planned, managed, and monitored by U.S. and Botswana partners, both for progress and for signs of slippage. Critical areas of focus in the transition are:

- **Negotiating and communicating priorities.** The U.S. embassy team has done an admirable job of communicating the goals of graduation to a range of stakeholders, but considerable ambiguity surrounding the graduation process remains. The United States will need to reemphasize that it is not abandoning Botswana or walking away from the partnership, a fear expressed among many Botswanans. Rather, the partnership is shifting to a new phase that will emphasize country ownership, an accelerated approach to prevention, improved health planning and management, and research—elements that will enable Botswana to achieve a longer-term goal of creating an AIDS-free Generation. The stakes are high because, in the face of increased uncertainty and a less-promising budgetary situation, Botswana may hesitate to move ahead with PEPFAR’s prevention recommendations.

A first step is to create a roadmap for shared responsibility and increased domestic investment. PEPFAR’s existing platform, the Partnership Framework on HIV/AIDS, outlines a general strategy for collaboration between Botswana and the United States to address HIV/AIDS over a five-year period, 2010 to 2015; the government of Botswana’s National Operational Plan (NOP) outlines major activities and anticipates costs for 2008 to 2010. Neither document includes expectations about how these costs will be covered through the relative contributions of the government of Botswana, PEPFAR, and other partners. Moreover, PEPFAR’s annual budgetary planning cycle imposes serious limitations on the U.S. government’s ability to make and keep multiyear fiscal commitments. Clearly, more intergovernmental dialogue will be needed to negotiate precise terms for the transition, anticipate technical assistance and resource requirements, create a monitoring framework, and agree on key milestones. It is noteworthy that the governments of South Africa and the United States have recently signed a joint roadmap for the transition of the PEPFAR program.

- **Accelerating prevention.** The United States will need to engage with the Ministry of Health, the National AIDS Coordinating Agency, and the Ministry of Finance and Development Planning to intensify HIV-prevention efforts and counter Botswana’s tendency toward complacency around HIV prevention. Diplomatic engagement with senior government leadership should convey U.S.

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expectations for robust and consistent commitment to combination prevention and the scale-up of efficacious interventions with sufficient coverage.

The administration’s approach for creating an AIDS-free Generation sets high-level goals, while permitting PEPFAR agencies and Botswana implementers the latitude to tailor their efforts to local situations, adapt to different epidemic scenarios, and make course corrections as new science emerges. At a time of fiscal constraint, the United States will need to maintain disciplined leadership to steer a difficult course in Botswana, quell any tendency toward interagency disputes, and negotiate unpopular trade-offs.

- **Increasing community ownership and engagement.** The United States will need to continue its targeted investments in strengthening Botswana’s nongovernmental organizations. In Botswana, insufficient urgency around HIV/AIDS and low levels of community engagement currently create a drag on HIV-prevention and treatment efforts. Community ownership and engagement is essential if the response is to be built upon a lasting and sustainable foundation. As government services are streamlined to suit new budgetary realities, nongovernmental organizations can help maintain program momentum and ensure that communities play meaningful roles in creating demand for prevention and treatment services, reaching vulnerable and hard-to-reach populations, and supporting HIV-positive people and their families.

- **Investing in health planning and management capacity.** U.S. technical assistance going forward should focus on a consequential program of health systems strengthening activities to improve health and human resource planning and management, find and address inefficiencies, and improve mechanisms of monitoring and accountability. Investments in some specific areas, for example, procurement and the supply chain, remain essential, although they can be time limited. PEPFAR should move cautiously in “sunsetting” personnel secondments, particularly in areas of planning, strategic information, health financing, and procurement and supply chain management. Failure to phase out these positions in a consultative, strategic manner may create prolonged vacancies and jeopardize progress made to date.

- **Continuing to invest in a robust research agenda.** Botswana’s contribution to the global evidence base on HIV treatment and prevention is already considerable, and the United States should continue to invest in seminal research studies that directly benefit the people of Botswana and strengthen the global HIV/AIDS response. The CDC-funded combination prevention trial promises to provide information essential for understanding the effectiveness of combination prevention approaches. Knowledge gained from this research must ultimately improve HIV/AIDS programs in Botswana, rather than set unrealistic or unachievable expectations for a national health care system that some say is already “gold plated” and therefore unsustainable.

Botswana’s Voluntary Medical Male Circumcision (VMMC) Campaign

In 2007, WHO and UNAIDS recognized VMMC as an important intervention to reduce the risk of HIV infection in men. At the time, modeling studies suggested that male circumcision in sub-Saharan Africa could prevent 5.7 million new HIV infections and 3 million deaths over 20 years. With HIV prevalence estimated to be over 25 percent among 15 to 49 year olds and with only 11 percent of men circumcised, Botswana was one of 14 countries targeted for rapid scale-up of VMMC services.¹

Botswana responded quickly to the WHO and UNAIDS recommendations. Within a year, Botswana had developed a national policy and operational strategy. In 2009, the national program launched an ambitious campaign to increase VMMC coverage to 80 percent of adult men by 2016.²

Despite initial enthusiasm, Botswana’s VMMC campaign did not take off as rapidly as expected. When President Mogae left office in 2008, clear political support waned. Botswana’s strategy to integrate VMMC services within existing health services proved difficult, and a lack of dedicated staff and surgical space for VMMC resulted in far fewer procedures than anticipated. With technical assistance from PEPFAR and the African Comprehensive HIV/AIDS Partnerships (ACHAP), Botswana took steps to remedy lackluster performance. Beginning in 2011, dedicated VMMC sites served as “one-stop shops” where men received HIV testing and counseling, surgery, and postoperative services. Acceptance of VMMC increased, and by October 2012, over 55,000 men had been circumcised, over half of them in the previous 10 months.³

Yet, in 2012, challenges remain. With a new plan for VMMC taking form, experts cite three major challenges:

1. **Demand creation.** While school campaigns have been successful in reaching teenagers, nongovernmental organizations can strengthen their efforts to increase demand among older adult men and build support among women.
2. **Human resource capacity.** Botswana’s VMMC guidelines stipulate that trained medical doctors should perform procedures. While Botswana has shifted some tasks away from physicians to nurses and other personnel, shortages of skilled professionals persist.
3. **Supply chain management.** Maintaining a consistent supply of critical commodities such as HIV tests and VMMC surgical kits is critical and problematic. To address this issue, facilities have started to compile consumption data to share with the National Medical Store to better match supply to demand.

³ CDC official, correspondence with author, August 2012.

Accompanying research on costs (which is already underway) is a step in the right direction because it helps to make research a win-win situation for Botswana and the United States.

Lastly, as PEPFAR and the international community advance the goals of creating an AIDS-free Generation, a note of caution is in order. Many of the findings that support the approach have only emerged over the past few years; many questions remain unanswered. In a dynamic context, it is important that the United States provides global leadership, conveys its support to HIV/AIDS research including research on how best to implement programs, and demonstrates its commitment to integrating findings as they emerge.
Conclusion

Botswana is better positioned than most to create an AIDS-free Generation, even as support from PEPFAR is reduced. Moreover, Botswana’s transition has important implications for other PEPFAR countries; in the words of a senior U.S. government official, “If we fail, it will have very significant implications for this effort elsewhere, because for all the weaknesses that exist here, there just aren’t many PEPFAR partners as capable and willing.”

PEPFAR’s transition in Botswana is about much more than managing a budgetary “glide path,” where direct funding declines progressively on a predetermined trajectory. PEPFAR’s transition is about achieving success. Despite Botswana’s remarkable accomplishments, meeting the ambitious objectives of an AIDS-free Generation will require concerted high-level focus, systematic negotiation, increased urgency around prevention, rigorous science, and some strategic investments of resources to meet new goals and prevent backsliding in the areas where Botswana has made significant progress. The U.S. government will need to maintain flexibility and adjust its investments to match the evolving needs of the HIV epidemic, to respond to unforeseen complexity, and to take advantage of new opportunities—all managed on a declining budget.

Yet, the reduction of U.S. funding need not diminish the progress of Botswana’s national HIV/AIDS program. In fact, as one official pointed out, it will ultimately compel Botswana’s government to streamline efforts, choose among competing priorities, increase efficiency, and think strategically about sustainability and financing.

The process of transitioning PEPFAR to a technical assistance model, in which HIV services are country owned and increasingly country financed, is already underway. After 10 years of investment, and much encouraging progress, the United States should continue to invest in getting the transition process right.
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