

## BOTSWANA

### HOW THE DECLINE IN PEPFAR FUNDING COULD AFFECT KEY POPULATIONS

*Brief*

## The Issue

Due to social and political barriers, many governments have been slow to directly support HIV services for key populations (KPs)—men who have sex with men (MSM), sex workers (SW), people who inject drugs (PWID), and transgender people (TG). This hesitation has historically led donors to provide the bulk of, or in some instances all, funding for KP-specific programs. As donor budgets for HIV have flat-lined, funding for HIV services and programming has decreased, particularly in countries with higher income status and concentrated HIV epidemics. This trend has left key populations especially vulnerable.

PEPFAR funding for HIV in Botswana began its slow decline in 2008. Since then, concern has mounted over how the transition away from a primarily donor-supported HIV program would affect key populations and the country's HIV epidemic. In 2015, to examine the implications for key populations of reduced PEPFAR funding in Botswana, the USAID- and PEPFAR-funded Health Policy Project (HPP) conducted a desk review and 10 key informant interviews with civil society, local government, and international donors. The resulting case study offers recommendations on how donors can best ensure the resiliency of HIV programming for key populations in Botswana and beyond.

## The Context

Botswana—a Southern African country with a population of two million—is home to one of the world’s most severe generalized HIV epidemics. With the second highest HIV prevalence rate in the world, just under one-fifth of Botswana’s population (18.5%) over 18 months of age is estimated to be living with HIV (Statistics Botswana, 2014).

In Botswana, as in most countries, reliable data on key populations are difficult to collect and verify. In 2012, data on female sex worker (FSW) and MSM population sizes and HIV prevalence were collected for the first time. The 2012 survey estimated that there were approximately 4,000 FSWs in the three regions included and just over 780 MSM in Botswana’s two largest urban areas (Gaborone and Francistown). The researchers who collected the data acknowledge the small sample size may be due to difficulties identifying MSM, and also caution that the MSM included in the sample had a low mean age, and HIV prevalence among older MSM may be higher. Although prevalence among MSM was found to be lower than among the total population, it was higher than the 7.5 percent prevalence found in a comparable group of 20–24 year old males. Additionally, HIV incidence among MSM is 3.6 percent, which is higher than the national rate of 1.35 percent. HIV prevalence among FSW is 61.9 percent, with an estimated incidence rate of 12.5 percent (Botswana Ministry of Health, 2013). Currently, no verified population size or prevalence data are available on TG people or PWID.

## The legal and social context

Laws in Botswana prohibit prostitution, and informants report that sex workers are often arrested and charged with other offences, including loitering. Same-sex relations are effectively criminalized via laws prohibiting “carnal knowledge of any person against the order of nature” and “act[s] of gross indecency,” although these laws are not specific to homosexual people. According to a recent survey, six out of 10 Botswana would 1) object to sharing a work environment with a colleague or supervisor who was in a same-sex relationship; 2) object to sharing a religious community or neighborhood with a homosexual person; and 3) would report people involved in same-sex relationships to the police (Lekorwe and Moseki, 2014).

### Botswana-at-a-Glance<sup>1</sup>

**Population:** 2,219,900

**GDP per capita (current US\$):** 7,123

**HIV Epidemic Type:** Generalized epidemic

**Number of PLHIV:** 390, 000

#### HIV Prevalence:

Total population: 18.5%

FSW: 61.9%

MSM: 13.1%

TG: data not available

PWID: data not available

**International HIV Funding:** US\$67.35 million

PEPFAR Funding: US\$40.47 million

**Domestic HIV Funding:** US\$116.68 million

#### Existence of laws criminalizing:

Any aspect of sex work: Yes

Consensual same-sex relations: Yes

Drug use: Yes

<sup>1</sup>Population and GDP data come from World Bank, 2015; PLHIV data come from UNAIDS, 2014; Data on existing laws come from UNAIDS, 2015; Funding data come from Global Fund, 2014; Adult HIV prevalence rate comes from Statistics Botswana, 2014; Prevalence rates for FSW and MSM come from MOH, 2013; Prevalence rates for TG and PWID were not available at the time of publishing.

Structural discrimination directly inhibits KP programming. For example, Lesbians, Gays, and Bisexuals of Botswana (LEGABIBO)’s application for registration has been rejected twice by the Government of Botswana (GoB) on the grounds, according to civil society informants, that its “objectives are against societal law;” that the GoB “doesn’t recognize homosexuality;” and that registering such an organization might “disturb peace” (KI, 2015). This, even after the country’s High Court ruled in favor of the group’s application in 2014. Similarly, the SW-led civil society organization (CSO) Sisonke’s application for registration was also denied.

The GoB has undertaken minimal efforts to address HIV among FSW as a result of the new prevalence data, but has no programming to reach MSM, TG, or PWID (KI, 2015). *The Second National Strategic Framework for HIV/AIDS 2010–2016* (NSF) defines most-at-risk populations as “sex workers, truck drivers, seasonal farm workers, and construction workers,” without reference to MSM, TG, or PWID (Botswana National AIDS Coordinating Agency, 2009). Many CSOs, particularly KP organizations, express frustration with the government’s lack of progress in KP programming, noting that other African countries support KP programs in spite of similar legal and policy environments.

Uniformly, the key informants HPP interviewed said that key populations face numerous barriers in accessing health services, fueled by stigmatizing beliefs.

## The Funding

As one of the most stable economies in Africa, Botswana is an upper-middle-income country, spending an estimated 5.4 percent of its US\$15.8 billion gross domestic product on health (World Bank, 2014). Although there is a shortage of reliable data on HIV funding in Botswana, key informants agreed that the GoB provides the majority of HIV funding. According to the 2012 *National AIDS Spending Assessment*, Botswana spent a total of US\$369 million on HIV, of which less than one-third was provided by international donors (U.S. Department of State, 2015).

PEPFAR has invested over US\$700 million in Botswana since 2004, including modest but pioneering support for KP interventions since 2008. Currently, PEPFAR is Botswana’s largest international donor and its largest supporter of KP programming. Despite this, KP programs comprised only 2 percent of PEPFAR’s 2014 portfolio (U.S. Department of State, 2015).

Historically, significant donor funding for HIV came from The African Comprehensive HIV/AIDS Partnerships (ACHAP), a public-private partnership between GoB; Merck & Co., Inc.; the Merck Foundation; and the Bill & Melinda Gates Foundation. From 2000–2014, the Merck and Gates foundations contributed US\$138.9 million and Merck donated large volumes of antiretrovirals (ARVs) (Geertz et. al., 2014). The end of

“If we don’t allow key populations to access quality services like the general population, it will be our own undoing.”

– Multilateral development partner

this investment has affected service delivery levels and there have been commodity stockouts as the GoB tries to fill the gap left in the wake of this transition (KI, 2015).

In 2015, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) approved US\$27 million over three years for Botswana to address HIV and tuberculosis (TB), including prevention efforts for MSM and TG (US\$1.4 million) and SWs and their clients (US\$1.68 million) (U.S. Department of State, 2015).

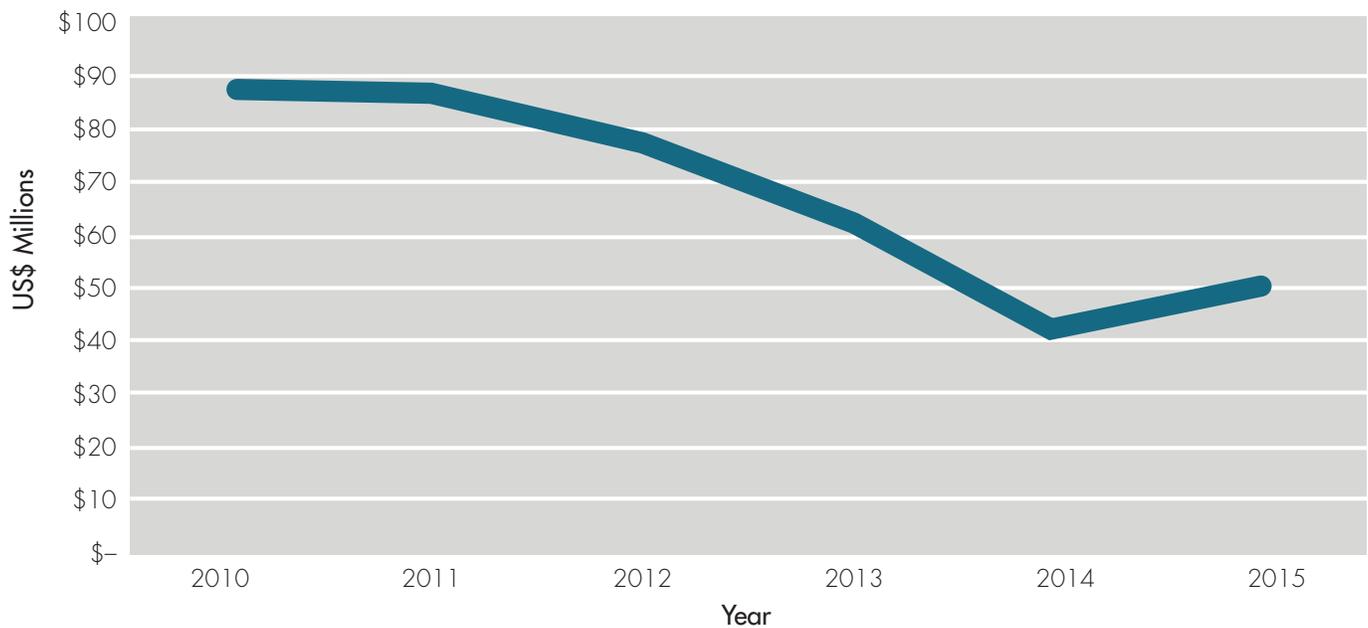
Despite the GoB’s demonstrated financial support of HIV programming, the government has yet to allocate funding for any KP-targeted HIV services, citing the lack of a legal framework (KI, 2015). International donors and development partners (including PEPFAR, the Global Fund, the Joint United Nations Programme on HIV/AIDS [UNAIDS], and the World Health Organization [WHO]) have supported CSOs to provide services to key populations and have attempted to build CSOs’ advocacy capacity.

## PEPFAR’s Transition

PEPFAR funding for Botswana peaked in 2008 at US\$93.2 million, after which funding began a slow decline to US\$40.5 million in 2014 (see Figure 1). At the same time, the Partnership Framework for HIV/AIDS, 2010–2014 between the U.S. government and the GoB shifted the PEPFAR program toward a technical assistance model.

In recent years, PEPFAR has seen its role as building the GoB’s capacity to oversee HIV programs and fostering the incremental development of KP programming through its support for both the Ministry of Health (MoH) and CSOs. A global USAID- and PEPFAR-funded project focused on reducing transmission among key populations—Linkages across the Continuum of

**Figure 1.** PEPFAR funding to Botswana, FY2010–FY2015



Source: Compiled by HPP from PEPFAR Dashboard and Country Operational Plans

“Stakeholders are not ready for the transition and still believe that it won’t happen.”

– Multilateral development partner

HIV Services for Key Populations Affected by HIV (LINKAGES)—is anticipated to begin implementation in Botswana in early 2016. Nevertheless, PEPFAR’s attempts to persuade the GoB to implement KP programming have been met with only slow and incremental success. Referring to USAID’s HIV Prevention Intervention for Most-at-Risk Populations project (2008–2013), PEPFAR noted “the policy environment was not conducive to key populations interventions and thus the partnership with Government was informal and lacked critical service support” (PEPFAR Botswana, 2014).

Some analyses suggest that, with careful planning, Botswana is well-positioned to fund all, or nearly all, of its national HIV program (Resch et al, 2015; Stegman et al, 2013). Yet neither GoB nor donors have formulated transition plans or timelines, and it remains to be seen

whether existing KP programming will be sustained or scaled up as donor funding decreases (HPP Interviews, 2015). It is worth noting that, while the overall funding envelope for HIV has been declining, KP-specific donor funding has risen.

## The Challenges

The PEPFAR transition in Botswana poses significant risks for key populations—particularly given the country’s current legal and policy environment and the GoB’s historic reluctance to support KP programs. As international donors scale-back, Botswana faces a number of challenges.

### Persistent stigma and discrimination

Key populations in Botswana are criminalized and advocates expressed frustration with the prospects for legal and policy reforms (KI, 2015). Many key populations, in particular FSW and MSM, suffer from persistent stigma and discrimination that often results in violence. CSO informants say that sexual minorities

report being beaten by their parents or church communities in an attempt to “reform” them, and to being threatened with imprisonment by the police when they report the attacks. Similarly, FSWs are often the victims of violence, at the hands of both clients and the police, who sometimes confiscate condoms as evidence of prostitution or blackmail sex workers for sex.

## Omission of key populations from the national response

The GoB has not assumed responsibility for the implementation of an appropriate HIV response for key populations within its national programs and services, and CSOs fear that when donors withdraw, KP programming will end. Meanwhile, GoB officials claim that the lack of an enabling policy or legal framework prevents them from targeting programs to key populations. While some MoH officials support a public health-driven approach that targets key populations, they have urged PEPFAR officials “not to ruffle feathers” and to “take one step at a time,” in recognition of the restrictive political, social, and legal environment (KI, 2015).

Botswana’s civil society enjoys only modest representation on HIV planning bodies. With the steady decline in donor funding that representation has further weakened and CSOs expressed concerns over sustainability. For instance, government representatives occupy 90 percent of seats on the National AIDS Council. For the most part, KP interests are represented by the Botswana Network on Ethics, Law, and HIV/AIDS (BONELA). However, many civil society representatives felt that BONELA is invited to participate only when it suits government interests, and that the organization’s views are rarely credited (KI, 2015). BONELA also sits on the Global Fund Country Coordinating Mechanism.

A KP technical working group (TWG), expected to convene in 2016, excludes MSM, TG, and PWID from its mandate. While their exclusion is problematic, KP groups take a pragmatic view, recognizing the need for incremental gains. As one CSO representative put it, “The TWG has to be acceptable to GoB, otherwise it will fail. If CSOs insist that it focus on MSM and LGBTI issues from the onset, then the TWG will not kick off” (KI, 2015).

## Lack of KP-friendly and KP-targeted services

According to PEPFAR, key populations are not being reached by mainstream HIV testing and counseling and treatment programs (U.S. Department of State, 2015). A recent survey showed that only 54.8 percent of FSWs had ever been tested for HIV. Among MSM, while 80 percent had ever been tested for HIV, only half reported receiving HIV information during the past year (Statistics Botswana, 2014), highlighting the need for targeted services. To date, the FSW test-and-treat program delivered by the Botswana Family Welfare Association has only reached 40 participants (out of a target of 1,000). Additionally, both MSM and FSWs report bias and discrimination in healthcare settings. In 2012, a PEPFAR-supported training program for healthcare workers on delivering KP-friendly services, convened by the National AIDS Coordinating Agency, “ended as a result of a lack of [GoB] support” (KI, 2015).

The GoB has stated that Botswana’s MSM population is too small to warrant targeted services and not restricted from accessing services in public health facilities. While there is acknowledgment that services are not always friendly to key populations, GoB officials have stated that service inclusivity could be improved with time and additional training of healthcare workers, without the need for policy changes. International donors and development partners have supported such trainings and note that service access and friendliness for key populations has improved in some public facilities, though they reaffirm that policy reforms remain urgently needed to ensure quality services for key populations across all health facilities.

“It’s the groups on the fringes that get impacted the most when [there are] funding cuts.”

– Multilateral development partner

## Low capacity among KP-focused CSOs

Botswana's KP-focused civil society is still emerging and has yet to find its collective voice. The few KP-led organizations operating in the country suffer from uncoordinated agendas and are often marginalized. The *PEPFAR Botswana Key Populations Strategy* notes, "There are limited sex workers and MSM lobby groups to push for policy change. The few existing groups are in competition for resources and do not speak in one voice" (PEPFAR Botswana, unpublished).

Further, capacity among Botswana CSOs to deliver services is limited. Many CSOs are wholly dependent on international donors and many fear that with the retreat of donor funding, Botswana's CSOs will not be able to sustain services. International development partners noted that, while many innovative programs have been piloted in Botswana, "great CSO projects are never sustained" (KI, 2015). PEPFAR's Botswana KP strategy notes, "The capacity to fundraise and maintain... organizational sustainability... have been major challenges for most CSOs working in this area. Most CSOs are deficient in programmatic technical expertise, management capacity, resources and basic infrastructure that would allow them to expand and sustain their operations." One KP representative commented, "If we lose international funding, where are we going to get the money to support awareness raising? We have a government that has the money, but [is] unwilling to fund KPs" (KI, 2015).

## Inadequate data to inform a targeted HIV response

Substantial information gaps impede KP program planning, monitoring, and evaluation in Botswana. For example, while the 2013 Botswana AIDS Impact Survey posed a few questions related to sex work, drug use, sexual orientation, and same-sex relationships, nothing related to these questions was included in the final analysis. Similarly, the 2012 behavioral and biological surveillance survey estimated population size, HIV incidence, and HIV prevalence among MSM and FSWs—a first for Botswana. However, the study was only conducted in three regions, limiting

its generalizability. Moreover, there is a general dearth of information pertaining to the TG population in Botswana and, although HIV rates among PWID are thought to be low, this population has also not been studied.

## Lessons Learned

Although Botswana has the potential to fund its entire HIV response in the future, donors must ensure that programming for key populations will be sustained before withdrawing completely. The following recommendations were developed based on HPP's interviews with a range of stakeholders leading and implementing HIV programs in Botswana:

1. **Invest in stigma-reduction efforts at ministry and health facility levels.** Persistent stigma is a root cause of the challenges key populations face in Botswana, including omission from national plans and the lack of adequate health services. Stigma-reduction efforts should work across multiple levels, targeting both decision makers as well as health facility staff. At policy level, sensitization efforts are a first step towards greater inclusion of key populations in the national response. At facility level, sensitization is urgently needed to ensure life-saving services are available to all populations.
2. **Invest in data for advocacy and decision making.** Data can be an invaluable tool in demonstrating program needs, but current KP-specific data is inadequate. By investing in better data, PEPFAR has the opportunity to demonstrate to the GoB that key populations not only exist in great numbers, but are currently underserved. This could help to improve the government's commitment to addressing HIV among key populations.
3. **Build capacity among CSOs to plan and implement sustainable programming for key populations.** Diverse stakeholders concur that, in light of legal and political hurdles to government-led programming targeting key populations, CSOs are best equipped to reach marginalized groups. CSOs have crucial roles to play in delivering interventions, acting as government watchdogs, and advocating for the rights and needs of key populations. To enable CSOs to carry out these roles effectively, there is an urgent need to build the capacity of CSOs—including KP-led organizations. CSOs are

particularly in need of strengthened program planning, implementation, and monitoring and evaluation skills. Coordination and networking between CSOs should also be strengthened.

4. **Create linkages between government and civil society.** Donors should use their convening power to bring together diverse stakeholders and facilitate dialogue around KP issues. Many KP-led organizations in Botswana are not currently registered, which limits their ability to receive donor funding and to sit on national coordination bodies. Engaging with civil society and government, both during Country Operational Plan consultations as well as regularly throughout the year, can improve relationships and increase transparency and accountability. Applying a readiness assessment tool, in collaboration with all stakeholders, could promote dialogue and help to monitor progress towards readiness benchmarks.
5. **Develop a minimum package of services for key populations.** Health clinic capacity to provide appropriate services to key populations is currently lacking in Botswana. As the government takes on increasing responsibility for KP services, formalized guidelines can help to standardize and safeguard quality of care.
6. **Ensure coordination between international development partners.** Donors and multilateral stakeholders (including PEPFAR, the Global Fund, WHO, and UNAIDS) should utilize the National Partnership Forum to align programming and negotiate collectively with the GoB on KP programming issues. This coordination is particularly important in light of Botswana's heavy reliance on donors for KP-specific programming.

## The Project

This case study is one in a series of four from Bangladesh, Botswana, China, and Guyana that seek to examine the implications for key populations of recent decreases in PEPFAR and other donor funding. Each case study is based on desk research and supplemented by key informant interviews with civil society, local government, and international donor representatives conducted in late 2015. Taken together, these case studies seek to provide lessons learned to guide PEPFAR in ensuring the resiliency of HIV programming for key populations.

For more information on how the decline in donor funding for HIV programming is affecting key populations and to access related case studies, please visit [www.healthpolicyproject.com](http://www.healthpolicyproject.com).

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