

Executive Summary

Adapting through Crisis

Lessons from ACHAP's Contributions to the Fight
against HIV/AIDS in Botswana



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African Comprehensive HIV/AIDS Partnerships (ACHAP)

Description:

Public-private partnership providing comprehensive, innovative and catalytic solutions to achieve sustainable population health, with a focus on HIV/AIDS

Original Partners

- Merck & Co., Inc. and Merck Foundation
- The Bill & Melinda Gates Foundation
- Government of Botswana

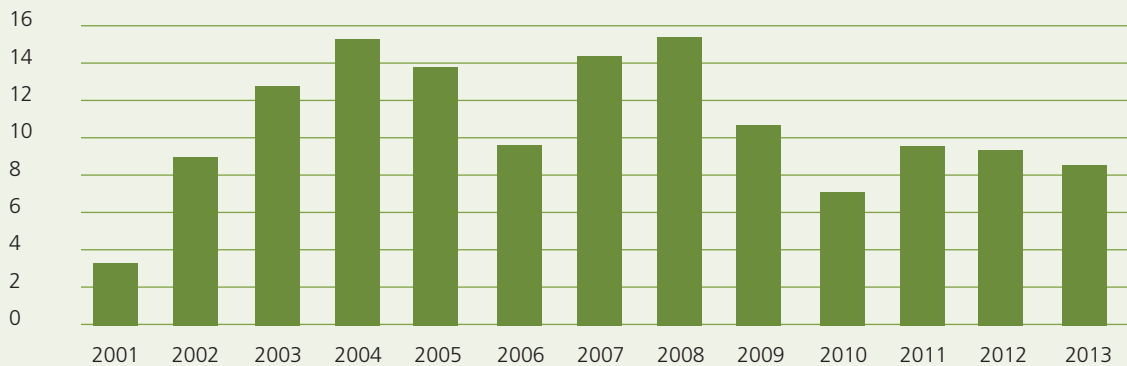
Timeframe:

2000 – Present

Total Funding:

\$138.9M

ACHAP Annual Spend (\$M)



Key Contributions

Examples

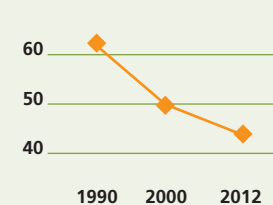
| | |
|--|---|
| ARV Treatment | <p>Donated ARV drugs and developed lab and clinic infrastructure to support ARV treatment reach 85% coverage</p> <p>Provided support to PMTCT program leading to coverage rates over 95%</p> |
| HIV Counseling and Testing | <p>Supported adoption of national opt-out HIV testing policy leading to 62% testing rates</p> <p>Helped develop counseling infrastructure and services</p> |
| Prevention Services | <p>Implemented safe male circumcision, contributing significantly to national targets</p> <p>Facilitated condom distribution and funded mass media and other prevention communication campaigns</p> |
| Tuberculosis Treatment and Prevention | <p>Supported establishment of national coordinating mechanism and TB policies</p> <p>Developed capacity and funded community organizations to implement DOTS</p> |
| Institutional Support | <p>Funded human resource positions and built internal government capacity at national and district levels</p> |

Botswana Health Statistics



Population: 2.004 million (2012)

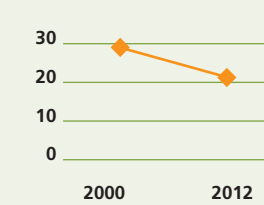
Life Expectancy



Deaths due to HIV per 100K population



Prevalence (% Adults)



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Overview

In 2000, Botswana was a country in crisis. The HIV/AIDS epidemic was ravaging the country, with an adult prevalence rate over 28 percent. Projections from the World Health Organization (WHO) indicated that 85 percent of 15 year-olds in the country would eventually die of AIDS. At the United Nations, President Festus Mogae commented, "We are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude."¹

In response to this crisis, Merck & Co., Inc., the Merck Foundation, the Bill & Melinda Gates Foundation (the Gates Foundation), and the Government of Botswana created the first public-private partnership to tackle the HIV epidemic at a national scale in sub-Saharan Africa. The African Comprehensive HIV/AIDS Partnerships (ACHAP) was formed in 2000, with substantial financial resources (US\$138.9M in total funding from the Merck and Gates Foundations), and large volumes of antiretroviral drugs (ARVs) donated by Merck. ACHAP was a pioneer in scaling treatment, working with the government to achieve the first widespread HIV treatment coverage on the continent, and influencing the formation of key global partnerships such as the US President's Emergency Plan for AIDS Relief (PEPFAR). ACHAP also helped strengthen the public health system in Botswana, and contributed to reducing the rate of new infections in the country.

¹ Maggie Farley, "At AIDS Disaster's Epicenter, Botswana Is a Model of Action." Los Angeles Times, June 27, 2001.

In late 2013, the Merck Foundation engaged FSG to conduct a strategic review of ACHAP, focusing on its successes, challenges, and lessons learned. This process is intended to document ACHAP's impact during the last 15 years of support while also informing future strategy and decision-making for four key audiences:

1. **ACHAP's leadership** as it contemplates its next phase of work in Botswana and beyond,
2. **The Government of Botswana** as it continues to manage the national response to HIV/AIDS in the country and also considers broader health needs,
3. **Merck and the Merck Foundation** through the company's business and corporate social engagement, and
4. **The global health community** as it manages existing and future health challenges of a national scope.

A team of FSG consultants conducted research for this review between August 2013 and June 2014, with inputs including:

- Over 75 key informant interviews with current and former ACHAP leadership and staff, Government of Botswana officials, local non-governmental organizations (NGOs) and community based organizations (CBOs), international NGOs, donor agencies, and current and former representatives of the funders of ACHAP.
- Three trips to Botswana including meetings with key stakeholders in Gaborone and Francistown as well as field visits to other areas in the northeast of the country.
- Review of hundreds of documents pertaining to ACHAP's strategy and operations, including prior evaluations of ACHAP's first phase of work and of specific programs, board meeting materials, annual reports, published articles, and financial reports.
- Review of external literature assessing ACHAP, HIV in Botswana, key interventions, and other public-private partnerships.

How Did ACHAP Perform in the Fight Against HIV/AIDS?

ACHAP's activities occurred in a dynamic and changing environment for HIV/AIDS in Botswana, and its contributions to the response need to be assessed against this context.

As shown in Figure 1, the HIV epidemiology of the country changed substantially, from an urgent national crisis to a longer-term challenge. New funders and other actors emerged, such as PEPFAR. The Government of Botswana changed as well, with a new presidential administration taking office midway through the partnership. Finally, new science emerged over the course of the 15 years, with substantial advances in the world's knowledge of both treatment and prevention of HIV.

Figure 1: Timeline of key changes in ACHAP's context (2000 – 2014)

| Critical Events and Factors in Botswana Requiring Adaptation | | | |
|--|--|---|---|
| | 2000 – 2004 | 2005 – 2008 | 2009 – 2014 |
| Botswana epidemiology | ◆ 2001: Botswana's adult prevalence HIV prevalence rate reaches 36% | | ◆ 2008: National ARV coverage rate reaches 80% ◆ 2010: Life expectancy begins to recover; new infections remain a challenge* |
| Presence of relevant actors and funders | ◆ 2001: CDC begins supporting HIV/AIDS research and interventions | ◆ 2004: PEPFAR begins funding HIV/AIDS efforts ◆ 2004: Global Fund begins funding HIV treatment & prevention; expands funding for DOTS therapy in 2008 | |
| Government engagement | ◆ 1998 – 2008: President Festus Mogae | | ◆ 2008 – Present: President Ian Khama |
| Knowledge of managing the disease | ◆ 1995 – early 2000s: Findings confirm effectiveness of fixed dose combination ARVs and PMTCT | ◆ 2005 – 2007: 3 RCT studies demonstrating efficacy of safe male circumcision published | ◆ 2011: HPTN 052 study demonstrates effectiveness of Treatment as Prevention |

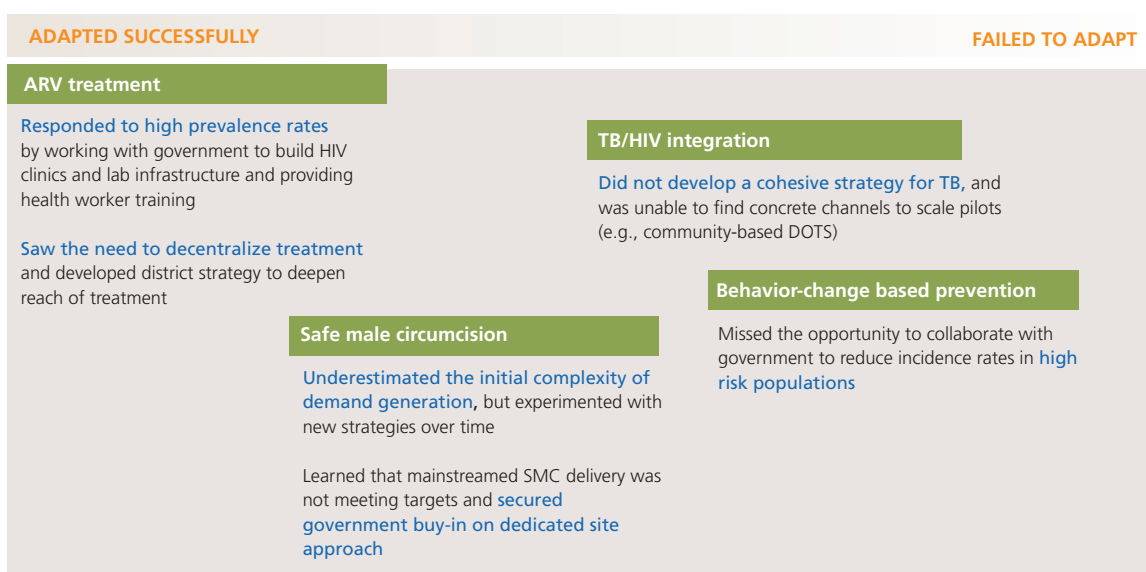
Notes: In 2010, life expectancy began to rise from a low of 46.2 years; between 2008 and 2012, HIV prevalence among 20-24 year olds rose from 26 to 34%
Sources: ACHAP Board Update (Jan 2014), Centers for Disease Control and Prevention, Global Fund, The Lancet, National Institutes of Health, New England Journal of Medicine, PEPFAR, UNAIDS, World Bank World Development Indicators

For this reason, the story of ACHAP is one of adaptation. ACHAP's contributions to the HIV response need to be assessed in the context of the changing environment; the key lessons from the public-private partnership are around how the organization successfully adapted – or failed to adapt – as the epidemiological, political, HIV/AIDS knowledge, and stakeholder contexts changed.

Examples drawn from major program areas of focus demonstrate both successes and failures in how the partnership adapted its programmatic offerings based on the changing circumstances (see Figure 2).

ACHAP also adapted key characteristics as an organization – again, in some cases successfully, but in others failing to adapt. For example, the board was small and comprised primarily of representatives from its funders until 2011, when it expanded and incorporated representation from Botswana for the first time. The backgrounds of ACHAP's senior leadership changed as well, initially emphasizing private sector, corporate experience, and then shifting to civil service backgrounds. The staff of ACHAP expanded substantially in the later years of the partnership, as the organization's role changed from one of catalyzing government and strategic planning to direct implementation and program management.

Figure 2: Summary of ACHAP's adaptation across four program examples



Achievements

Overall, ACHAP made strong contributions to the HIV response in Botswana, and the country is a success story among Southern African countries. Examples of areas in which ACHAP contributed to impact include:

- **Dramatic scale-up of antiretroviral therapy (ART) coverage:** Botswana's ART coverage rate is estimated at 85 percent of those in need¹, which is among the highest rates in sub-Saharan Africa. ACHAP worked with the government to build capacity and develop the initial infrastructure, forming the foundation for the national ARV treatment program. ACHAP also worked with the government to enact an opt-out HIV testing policy, which resulted in substantial increases in testing rates and in ART uptake.
- **Reduction in HIV mortality:** Deaths due to HIV per 100,000 population declined from 1,082 in 2000 to 284 in 2012 as a result of the significant increase in ART coverage rates².
- **Strong success in the prevention of mother-to-child transmission (PMTCT):** ACHAP contributed to Botswana achieving a PMTCT coverage rate over 95 percent and a transmission rate of 3 percent – making it the only African country to have already achieved by 2013 the UNAIDS 2015 target of reducing the MTCT rate below 5 percent in breastfeeding populations³. ACHAP partnered with CDC and contributed financial and technical support to ensure the success of the PMTCT program in Botswana.
- **Recent progress in scaling safe male circumcision (SMC), despite a slow start:** As of 2013, 24 percent of all 10 – 64 year old men were circumcised, more than double the rate in 2008⁴. ACHAP implemented SMC programs directly and became the biggest contributor to national circumcision goals.
- **Expanded impact by influencing program design of other funders:** Botswana's pioneering national ARV treatment program set an example for other programs in the region and informed the design of PEPFAR and the Global Fund⁵.

¹ The Government of Botswana is currently conducting an audit of its estimates of the number of people in need of antiretroviral therapy. Preliminary output from this analysis has indicated a coverage rate of approximately 85 percent. This process will also result in revisions to historical coverage rates based on changes in the methodology for estimating need.

² Calculation based on deaths data from UNAIDS 2013 Global Report and population data from World Bank DataBank.

³ "2013 Progress Report on the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive." UNAIDS, June 30, 2013.

⁴ Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.

⁵ FSG interviews

Challenges

In other areas where ACHAP played a role, either directly or through support to the government, the national response fell short. While not all of these areas of limited progress can be attributed directly to ACHAP, challenges include:

- **Limited progress on averting new infections, especially in young women:** Tracing the cohort of individuals aged 15 – 19 in 2004 finds that their prevalence rate tripled from 2004 to 2013⁶. Young women and girls are disproportionately affected, with prevalence rates among 25 – 29 year old women at 27 percent compared to men at 13 percent⁷.
- **Continued high rates of risk behaviors:** Rate of adults with multiple partners in the last year increased from 11 percent in 2001 to 16 percent in 2013⁸.
- **Major concerns around tuberculosis co-infection:** TB cure rates declined from 2009 to 2011; ACHAP contributed to expanded treatment coverage, but limited adherence to protocols in the public health system has stymied results⁹.
- **Remaining gaps in safe male circumcision:** The Government of Botswana revised its national targets to 385,000 adolescents and men aged 13 – 49 in 2011, but Botswana is still behind targets and declining donor funds for SMC may further inhibit future progress¹⁰.
- **Challenges with impact measurement and planning:** Government estimates of the total ART need still lack reliability, and there are still concerns over the financing of the program in the future¹¹.

⁶ Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.

⁷ Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.

⁸ Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.

⁹ 2012 Botswana National TB Program Annual Report

¹⁰ FSG interviews

¹¹ FSG interviews

How Successful Was ACHAP as a Public-Private Partnership?

ACHAP formed at a time when many other public-private partnerships (PPPs) on health issues were emerging. Examining this landscape of partnerships, FSG identified **five characteristics of successful PPPs** (Figure 3), drawing from external literature on PPPs as well as a landscape assessment of other partnerships on HIV and other global health issues. ACHAP's performance against these characteristics is mixed and nuanced. On characteristics such as adapting overall strategy and role, nurturing partnerships with government, and leveraging the power of the private sector, ACHAP provides both leading practices and areas for improvement. On investing in knowledge and planning for sustainability, ACHAP did not perform as strongly.

Figure 3: Five Characteristics of High-performing PPPs

| Adapt overall strategy and role | Leverage the power of the private sector | Nurture partnerships with government | Invest in knowledge | Plan for sustainability |
|---|--|--|---|--|
| <p>Shifted its programmatic approach from working within government system to executing independently</p> <p>Conducted limited strategic planning upfront, making it challenging to align resources internally and coordinate with partners as programs adapted</p> | <p>Leveraged entrepreneurial managers to develop new programs and approaches</p> <p>Did not adequately build in performance based management systems to ensure the organization's staff maintained private sector skills</p> | <p>Designed effective structures for engaging the government in regular planning and coordination</p> <p>Did not adequately adapt the government engagement mechanism as the organization shifted its programmatic approach and the government interests changed</p> | <p>Used data effectively to guide program-level tactical decisions</p> <p>Consistently under-invested in its own management information systems to support learning and evaluation</p> <p>Missed opportunities to invest in effective dissemination of its learnings to key global health audiences</p> | <p>Set up programs to be transferred to the government or other implementing partners but encountered challenges</p> <p>Ineffectively planned for the long-term sustainability of the organization</p> |
| ACHAP IS A LEADING EXAMPLE | | | AREAS FOR IMPROVEMENT | |

Adapt Overall Strategy and Role

- ACHAP successfully shifted its programmatic approach to stay relevant to the epidemic as the context for its work changed. ACHAP shifted from working within government systems to a more independent approach focused on innovating and piloting new programs.
- However, even after the initial crisis, ACHAP did not have a strategic plan in place. As a result, ACHAP was not able to be fully intentional in its efforts to make this shift from catalyzing government to direct implementation, nor was it transparent to the other key partners. For example, while ACHAP's initial flexibility was crucial in supporting the development of the first ARV treatment sites, once the treatment program was more established, ACHAP could have invested in the development of a strategic plan to support future growth and align internal resources.

Leverage the Power of the Private Sector

- ACHAP leveraged a nimble, independent group of managers with private sector skills to initially set up and scale the ARV treatment program. ACHAP shifted management and brought in new expertise and staff experience in an effort to transition to a more established organization. With this shift, ACHAP lost some of its private sector skill base, and did not adequately build in a performance management systems that would allow for regular performance assessment and review.
- ACHAP's funders committed to supporting the partnership without specific expenditure restrictions during the initial five years of funding, giving ACHAP's managers the flexibility to spend resources as needed and experiment with new programs that may take time to show results.

Nurture Partnerships with Government

- ACHAP was intentional about putting systems and structures in place to support its ongoing relationship with the government, and ensure alignment and buy-in from key government stakeholders at the national and local levels. These structures included the Madikwe Forum, which brought ACHAP's board and management together with the Permanent Secretaries from key ministries to align on strategy. ACHAP also seconded staff into ministries to ensure coordination at a tactical level.
- ACHAP was not as successful at maintaining high-level relationships with key government officials as government priorities shifted to other issues. ACHAP was established to support an ARV treatment program in concert with the government, and this model required significant engagement from the government to be successful. When the government's interests shifted, ACHAP lost some of its influence with political leadership. ACHAP struggled to achieve a similar level of success in other programs (such as safe male circumcision) using an approach that required such deep engagement from government. While ACHAP did not have control over the government's priorities, in developing new programs, ACHAP should have taken into greater consideration the extent to which it relied on the prerequisite of political will to implement its work.

Invest in Knowledge

- ACHAP was effective at using data to guide program-level tactical decisions. For example, when ACHAP was building the ARV treatment program, management quickly identified that low HIV testing rates were a barrier to increasing the number of patients on treatment. ACHAP supported the government to enact a national HIV testing opt-out policy which helped to drive up testing rates and facilitate expansion of treatment services.
- However, ACHAP consistently underinvested in its own management information systems to support broader learning and evaluation that would inform its overall strategy. ACHAP lacked adequate monitoring and evaluation (M&E) staff to develop a robust process for measuring impact, limiting its ability to integrate lessons into annual planning and share information across geographies.

- ACHAP also missed opportunities to invest in effective dissemination of its learnings. While the partnership published frequently in medical journals and put out robust communications pieces, it had a unique platform to conduct implementation research that would have been more practical and relevant to the field. ACHAP could have been more intentional in translating its academic contributions into practical insights for key global health audiences that would benefit from specific lessons in PPP design and management.

Plan for Sustainability

- ACHAP did set many of its program activities on a path toward sustainability by positioning programs to be transferred to the government or by engaging other implementing partners to provide support. However, there is still a lack of clarity as to how elements of ACHAP's successful programs will be sustained in the future: for example, in how the government will fund aspects of the ARV treatment program beyond the conclusion of ARV donations that support a part of the national ARV supply, and in the pace of public sector implementation of SMC.
- ACHAP and its funders were not effective in planning for the long-term sustainability of the organization. For example, despite the decrease in available funding following the departure of the Gates Foundation in 2012, ACHAP did not lay out a plan for longer-term funding support until 2013. Regardless of the intended direction (sunsetting or continuing to catalyze new areas in the HIV response), the partnership needed more concerted planning around goals for impact, accompanying milestones, and resource implications of these goals upfront to ensure that there would be resources available.

What Can Other Public-Private Partnerships Learn from ACHAP?

Based on the successes and challenges during ACHAP's 15 years of partnership, there are six key lessons that other public-private partnerships should incorporate into their work.

1

Emphasize adaptation as a core characteristic for successful public-private partnerships:

Partnerships looking to maintain relevance and impact in a dynamic context need to adapt at strategic, organizational, and programmatic levels. Several attributes can lay a foundation for public-private partnerships to adapt successfully:

- a. Emphasize nimble execution: Hire staff and management that take initiative, are results-driven, and move at a rapid pace to help the partnership to be reactive to the changing context. At the same time, be sure to identify opportunities to embed the private sector skills in government processes and culture.
- b. Leverage flexible funding: In the beginning, partnerships should prioritize a flexible funding structure to allow management to establish programs and test new practices in order to

2

Be intentional about strategic shifts and set a clear upfront strategy and milestones:

identify the appropriate path for reaching the partnership's goal. Once these visions and strategies are established, partnerships can shift to alternate funding structures that tie short-term results more closely to future funding decisions.

- c. Embed learning mechanisms early: Build relationships and take time to incorporate new data into planning early and often to identify new science, emerging partnership opportunities, and changing needs.

To encourage entrepreneurial activity and innovation, partnerships can allow for flexibility early on. However, all activities should be tied to clear goals and, once the initial programs are established, the partnership should create an explicit strategic plan with milestones and systems for measuring progress. The plan should assess the internal staff expertise and capabilities to evaluate if the partnership can execute on the plan, and identify any additional skills needed. The milestones can also prompt decision points for the partnership to assess whether or not to continue funding individual programs. Partnerships should also focus on building strategic relationships that will help with execution against the plan.

3

Design the appropriate governance and management structure:

Public-private partnerships should assess the expertise and guidance needed to execute the chosen strategy. For example, organizations can select a management team with private sector expertise and balance this with public sector or content expertise on the board. Alternately, partnerships can place funders on the board to maintain close relationships between the funders and the grantee. Either way, the partnership should be clear about the implications of the governance and management structures that it creates to anticipate opportunities or challenges.

4

Plan for sustainability and ensure there is ongoing communication between members of the partnership at the execution and leadership levels:

It is critical that partners begin with the end in mind: to ensure that progress will be sustained, they need to plan for the sustainability of programs upfront during the program design phase, and discuss potential exit strategies for the organization's initial funders. There is a need for partners engaged in the initiative to communicate about the partnership strategy and ensure alignment on program goals. In addition, partners should communicate at the leadership level to ensure the strategic directions of the participating organizations also align.

5

Develop capabilities in learning and evaluation as well as implementation:

Public-private partnerships need a mix of internal capacity development and external support in order to strengthen their abilities to collect and interpret data in a useful way and inform their own organizational planning as well as for the broader field. Partnerships also need to be intentional about their plans for disseminating best practices to the field by emphasizing relevant implementation research that responds to needs of other program managers, and by using diverse venues and practical formats beyond annual reports and academic publications.

6

Align the degree of government collaboration with the partnership objectives and build appropriate structures for coordination:

Partnerships need to design appropriate collaboration mechanisms that allow for alignment with government in order for partners to effectively execute and scale programs. How these collaboration mechanisms operate more specifically will depend on the partnership's objectives, resources available, government capabilities, and support needed to achieve the goals. There is a range of structures for collaboration: partners can engage with government by infusing private resources directly into government budgets, by forming hybrid collaborations such as ACHAP, or by launching private sector-led efforts that operate with light oversight from and coordination with government. Some may require less intensive relationships with a lighter coordinating forum while others may require a deeper collaboration with support across all levels of government.

Conclusion

ACHAP broke new ground in proving the feasibility of HIV treatment in sub-Saharan Africa. The successes of Botswana emboldened the global AIDS response, shifting the dialogue to emphasize aggressive targets for treatment scale-up. The partnership provides crucial lessons for other public-private initiatives, particularly in how it was able to adapt its strategy and role beyond the initial mandate, and in its early structures for engaging government. However, ACHAP also offers several cautionary tales for other public-private partnerships. It underinvested in learning and evaluation, insufficiently navigated the changing political context in Botswana, and belatedly planned for the sustainability of the partnership.

Going forward, there are tremendous opportunities for ACHAP and other partnerships to take these lessons into new arenas: for example, in the mainstreaming of HIV/AIDS services into the broader public health system, and in the response to the emerging burden of non-communicable disease in low- and middle-income countries. Hopefully, these future efforts will retain and strengthen the adaptive nature that ACHAP has displayed over its 15 years of impact on HIV/AIDS in Botswana.

References

- 1 Maggie Farley, "At AIDS Disaster's Epicenter, Botswana Is a Model of Action." Los Angeles Times, June 27, 2001.
- 2 Calculation based on deaths data from UNAIDS 2013 Global Report and population data from World Bank DataBank.
- 3 "2013 Progress Report on the Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive." UNAIDS, June 30, 2013.
- 4 Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.
- 5 FSG interviews
- 6 Botswana AIDS Impact Survey IV (BAIS IV) Summary, Statistics Botswana, 2013.
- 7 Ibid
- 8 Ibid
- 9 Unpublished document "Botswana National TB Program Annual Report 2012."
- 10 FSG interviews
- 11 FSG interviews



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Cover Image Credit: Harvard School of Public Health AIDS Initiative



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