Until recently, Botswana had one of the world’s fastest economic growth rates, and is now an upper-middle income country with one of Africa’s highest GDPs. The poverty rate remains at about 20% in a country of just 2.2 million people. The government has invested heavily in its health system; Botswana is just one of three African countries to meet the objectives of health spending of the Abuja Declaration. At 18.5%, the prevalence of HIV in Botswana remains among the highest in the world. HIV prevalence peaks between ages 35-49 years at an estimated 43%. HIV prevalence among sex workers in Gaborone, Francistown, and Kasane is estimated at 61.9%. High coverage of treatment for populations that are HIV positive, complemented by relatively high rates of condom use, have contributed to a decline in incidence. Behaviors driving the epidemic include concurrent partnerships, multiple partnerships, intergenerational sex, and sex work. Other factors contributing to HIV in Botswana include low marriage rates, and late age at first marriage - just 50% of the sexually active population indicated that their most recent partner was either their spouse or live-in partner. While the epidemic is generalized, populations at risk include youth, refugees, prisoners, and women. Key populations at particular risk include sex workers (SW) and men who have sex with men (MSM).

Condom distribution in Botswana meets a relatively high 70% of total condoms needed to achieve national use targets. An additional 12 million condoms are required annually to address the gap between current use and need. Condom use has remained consistently high for the last 10 years; SW report over 90% use at last sex with clients, but consistent use drops to 65% with non-cohabiting partners. Only 65% of young couples (15-24) report consistent condom use with their non-regular partner. As in most other markets, reported use by women trailed that of men by about 5%. Those data points are aging, and two important studies updating use with key populations (SW and MSM) and the general population will be available later in 2017. Until the findings from these two studies are released, it is difficult to map out the current trend in use.

While use by wealth quintiles is not available, condom use is significantly lower for individuals with non-regular partners that had no formal schooling, and for people from rural areas – an imperfect proxy measurement of equity. Condom use does not vary dramatically by age (with

---

2. The Abuja declaration states the average government expenditure on health, as a percentage of total government expenditure to more than the 15% target.
4. Ibid.
7. 2012 Behavioral and Biological Surveillance Survey (BBSS)
9. Field work supporting the 2017 Behavioral and Biological Surveillance Survey (BBSS) will commence in quarter 3 or 4 of this year, while the Botswana AIDS Impact Survey (BAIS) V will occur in a similar if not later period.
the notable exception of those aged 25-29, where use lagged approximately 5% below other
groups) and with a few district exceptions.\textsuperscript{10} At 68%, condom use in rural areas trailed use in
urban areas by 8%, but 58% of the population is urban.

An estimated 28.4 million condoms were distributed
through the public and
commercial sectors last year,
rebounding after 3 years of
steady decline with the
departure of social marketing
programs in 2013. Public
sector contribution to use has
remained consistent,
delivering approximately 82%
of condoms used in Botswana
since 2010. Access to free
condoms has increasingly
relied on facility (clinic) based
distribution, which has limited the absolute number of free condoms distributed given supply
chain challenges, the limitation of reach of the public health system, and the preferences of
specific populations such as SW and youth to access condoms at discreet locations. While the
commercial actors have largely filled the gap in volumes lost when Population Services
International’s (PSI) social marketing program ended in 2013, evidence indicates the departure
of PSI contributed to a decline in the overall number of condoms distributed in Botswana, the
impact of which is described in more detail below. It is important to note early in this study,
\textit{that plateaued distribution (and use) cannot simply be attributed to insufficient supply of
condoms} – public sector condoms are now available in nearly unlimited quantities through
Government of Botswana (GoB) domestic commitments to fund commodity procurement.

The government has leveraged its attainment of upper middle-income status to support one of
the highest rates of investment in health care in Africa\textsuperscript{11}. Coinciding with increased domestic
investment is the decline in external funding supporting prevention efforts. Some of that gap
has been covered by increased GoB budget support, although data were not sufficient to
quantify funding for condom-related prevention activities. Botswana’s reliance on domestic
funding, complemented by a robust commercial sector, has limited its exposure to the peaks
and valleys of condom procurement driven by external funders that other countries experience.
As such, it has one of the continent’s most stable condom markets, capable of addressing future
needs.

\textsuperscript{10} At 52% Condom use with non-regular partner is significantly lower in Ngwaketse West, with the districts of Jwaneng, Kweneng
West, Central-Tutume, Ngamiland South all reporting just below 67% condom use.

\textsuperscript{11}
Donor funding is particularly important to extend the reach of prevention interventions to vulnerable populations such as SWs, MSM, and youth, whom the government struggles to support through its existing infrastructure. Such investment continues to be necessary even within the context of the GoB’s existing investments in health systems, and can play a complementary and critical role in preventing new infections. The USG’s PEPFAR program remains Botswana’s largest external donor, currently supporting prevention efforts at approximately $2.8 million/year. The program with a focus on supporting prevention elements of the cascade to treatment programs through support to FHI/360 and ACHAP. A new Global Fund award specifically targets prevention programming among youth, SW, and MSM. The final award of $550,000, however, was reduced from a requested $8 million for prevention programming - leaving a gap to support prioritized prevention programs. The GoB currently provides internal budget support to procure as many condoms as systems can absorb, but provides somewhat limited and ad hoc support for demand creation and distribution activities.

Questions for Discussion:

1. Explain why you think the statement “plateaued distribution (and use) cannot simply be attributed to insufficient supply of condoms” was made.
2. From the perspective of a healthy market, where do you think Botswana’s market is (healthy markets are defined as increasing volumes, supporting increasing use, and decreasing reliance on external subsidy).
3. Why is the reliance on facility based distribution problematic for Botswana?