

**SEXUAL AND REPRODUCTIVE HEALTH RIGHTS
(SRHR) AND HIV & AIDS LINKAGES INTEGRATION
STRATEGY AND IMPLEMENTATION PLAN**

i. ACKNOWLEDGMENTS

This is the first edition of the SRHR/HIV Linkages strategy for Botswana. This strategy is the result of the concerted efforts, hard work and generous support and guidance of the Department of HIV and AIDS Prevention and Care, Department of Public Health-specifically the Sexual and Reproductive Health Division, Department of Health Policy Development Monitoring and Evaluation, Health Training Institutions-specifically Gaborone Institute of Health Sciences, UN agencies, Development Partners, Civil Society Organizations and other stakeholders- with funding from European Union and UNFPA.

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ii. Foreword

In September 2006, the African Union adopted the 'Maputo Plan of Action', calling on countries to "strengthen commitment to achieving universal access to Sexual and Reproductive Health Services, including Family Planning." In 2010 the Southern African Development Community recognized strengthening Sexual and Reproductive Health and Rights (SRHR) and HIV linkages as key to achieving its target of a 50 percent reduction in new HIV infections by 2015. A growing body of evidence suggests that better linking of efforts in addressing HIV and SRHR produces mutually reinforcing progress in both areas. Reinforcing and scaling up linkages between HIV and SRHR is therefore critical for the achievement of the health related Millennium Development Goals namely: 4(Reducing child mortality); 5(Improving maternal health) and 6(Reducing new HIV infection).

Botswana is committed to improving the health and socio-economic status of its people. In order to achieve these goals, Government is implementing various programmes and strategies that have led to the achievement of high coverage rates and positive health indicators. The success of these interventions include immunization of the 1 year old children (90%), attendance of antenatal care clinics by pregnant women (94.1%), births/deliveries attended by skilled personnel (94%), HIV-infected pregnant women receiving ART for PMTCT (94%), and MTCT rate of 4%.

Despite these achievements, Botswana is one of the countries mostly affected by HIV and AIDS with HIV prevalence of 17.6% (2008 BAIS III report) as compared to 17.1% in 2004. In addition neonatal mortality is 34/1000; maternal mortality rates (163/100 000) and these may reflect inadequacy in the provision of quality child health, sexual and reproductive health and HIV and AIDS services.

Botswana Government, through Ministry of Health therefore undertook a Rapid Assessment of Sexual & Reproductive Health and HIV and AIDS linkages in 2008. The main purpose of the assessment was to gauge the existence of bi-directional linkages at policy, systems and service delivery levels; to identify gaps between the two areas and ultimately develop measures to strengthen and bridge these gaps. Analysis of the rapid assessment identified occurrence of linkages at service delivery as opposed to policy level. In addition, there were weak linkages of HIV and AIDS to SRH programmes and services; hence strengthening of bi-directional linkages between HIV and AIDS with SRH was strongly recommended.

It is for this reason that an SRHR/HIV linkages strategy together with its implementation plan has been developed. This strategic document will guide implementation, monitoring and evaluation and coordination of SRHR/HIV linkages in this country.

It is my hope that health care providers, governmental ministries and departments, civil society organizations, development partners and all other stakeholders will join forces towards achievement of the MDGs through implementation of this strategy.



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i. LIST OF ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome

ANC - Antenatal Care

ART - Antiretroviral Therapy

ARV - Antiretroviral

ASRH - Adolescent Sexual Reproductive Health

AU - African Union

BAIS - Botswana AIDS Impact Survey

BCIC - Behaviour Change Intervention Communication

BHP - Botswana Harvard Partnership

BOCAIP - Botswana Christian AIDS Intervention Programme

BOCCIM - The Botswana Confederation of Commerce

BOCONGO - Botswana Council of NGOs

BOFWA - Botswana Family Welfare Association

BONASO - Botswana Network of HIV/AIDS Service Organisation

BONELA - Botswana Network on Ethics and Law

BONEPWA - Botswana Network of People Living with HIV/AIDS

CDC - Centers for Disease Control and Prevention

CHBC - Community Home-Based Care

CSO - Civil Society Organization

CWC - Child Welfare Clinic

DAC - District AIDS Council

DHMT - District Health Management Team

DMSAC - District Multi-Sectoral AIDS Committee

EU - European Union

FHI - Family Health International

FP - Family Planning

GBV - Gender Based Violence

HIV - Human Immunodeficiency Virus

IDCC - Infectious Disease Control Centre

IEC - Information Education and Communication

Industry and Manpower

I.H.S - Institute of Health Sciences

IPMS - Integrated Patient Information Management System

IPPF - International Planned Parenthood Federation

M&E - Monitoring and Evaluation

MCH - Maternal and Child Health

MCP - Multiple and Concurrent Partnerships

MDGs - Millennium Development Goals

MOH - Ministry of Health

NACA - National AIDS Coordinating Agency

NGO - Nongovernmental Organization

PIMS - Patient Information Management System

PLWHA - People Living With HIV and AIDS

PMTCT - Prevention of Mother-to-Child Transmission

PNC - Postnatal Care

RC - Reference Committee

RH - Reproductive Health

RHT - Routine HIV Testing

RTI - Reproductive Tract Infection

SMC - Safe Male Circumcision

SMI - Safe Motherhood Initiative

SRH - Sexual Reproductive Health

SRHR - Sexual Reproductive Health and Rights

STI - Sexually Transmitted Infection

TAC - Technical Advisory Committee

TB - Tuberculosis

UB - University of Botswana

UNFPA - United Nations Population Fund

UNICEF - United Nations Children's Fund

VCT - Voluntary Counseling and Testing

WHO - World Health Organization

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vi. DEFINITIONS OF KEY WORDS AND THEMES

Integration: This refers to different kinds of SRH and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes. This would include referrals from one service to another, for example. It is based on the need to offer comprehensive and integrated services.¹

Linkages: The recognition that HIV infections are sexually transmitted or associated with pregnancy, childbirth, breast feeding and that there are interactions between them and that sexually and reproductive ill health and HIV&AIDS share root causes including poverty, gender, inequality and social marginalization.²

The bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV. It refers to a broader human rights based approach, of which service integration is a subset.

Bi-directionality: Linking SRH with HIV related policies and programmes and linking HIV with SRH related policies and programmes. The diagram below depicts bi-directionality.

Bi-directional linkage



Models for integrating SRHR and HIV and AIDS:

The 'Mall': Similar to the definition of malls, this is where SRHR and HIV services are provided in compartments due to the infrastructure nature of the facility. All services are available but not in one location. Users normally move from one location within the facility to another to access the services that are supposed to be linked. Service providers are qualified to provide comprehensive services. This model is normally found in primary, district and referral hospitals in the country.

The 'Supermarket': The name implies service provision from one or separate rooms but at an assigned location. SRHR and HIV and AIDS services are linked and provided in this location within the facility by trained health providers. Pharmacies are also linked.

The 'Kiosk': This is where comprehensive service provision is limited by space and personnel. It is mainly found at health posts and mobile stops. Services are usually provided in one or two rooms.

Clients and users: These are the individuals receiving SRH and HIV&AIDS services in a facility. In the report they are used interchangeably.

The rights based approach to sexual reproductive health³: SRH rights derive from fundamental human rights and freedoms that are already enshrined in the constitution of Botswana and are included in several international agreements and treaties to which the government of Botswana is a signatory. (See Annex for international agreements and treaties).

The elements of client rights include:

- Right to factual and scientific information on SRH
- Right of access to services regardless of social status, economic situation, religious affiliation, ethnic origin, marital status or geographic location
- Right of choice to SRH services
- Right of safety in the practice of SRH
- Right of privacy during discussions or basic examination
- Right to confidentiality- information provided must not be communicated to anybody without consent but counseling should strive for shared confidentiality

¹ WHO, UNAIDS, UNFPA, WHO (2008). Gateways to integration: a case study series.

² ibid

³ Policy Guidelines and Service Standards SRH: Ministry of Health, Gaborone Botswana

- Right to dignity- treatment with courtesy consideration, attentiveness and full respect regardless of level of education, social status, age, etc.
- Right to comfort when receiving services
- Right of continuity of SRH care, services and commodities
- Right of opinion- to express their views on the type of services they receive

The rights upholds the basic rights of couples and individuals to attain the highest standards of sexual and reproductive health and to decide freely (without discrimination, coercion or violence) and responsibly the number and the spacing of their children and to have access to information and education, to make informed choices and the means to do so.

People with disability: These rights cover all people in the country but given that people with varying degrees of disability exist in the society and may require special attention and care particularly regarding issues of their sexuality⁴, this project should take the opportunity to give service providers the orientation they require to provide distinguished service. Additionally, their institutions should be included in training and orientation sessions planned at the pilot phase of the project. The disabilities include; the hearing impaired, sight impaired and mentally and physically challenged. Furthermore material development processes should consider their special needs e.g. material in Braille format for the sight impaired.

Emerging population targets: The population targets in question include: -

- Injecting Drug Users (IDUs),
- Those with different sex orientations e.g. Transgender Sex (TS)
- Sex workers
- Those in Intergenerational sexual unions
- Those in Multiple -Concurrent Partnerships (MCP)
- Children adolescents and youth born with the virus and are living with it
- PLWHAs

Health Facilities: These include health provision at referral hospitals, primary hospitals, district hospitals, clinics (with and without maternity wings), health posts and mobile stops. There are 630 in total health facilities and 876 mobile stops in 28 DHMTs in the country. The breakdown is 3 referral hospitals, 14 general hospitals, 17 primary hospitals, 279 clinics and 351 health posts⁵. In addition, there are private hospitals and clinics, mission hospitals and those for the Botswana Defence Force, the Botswana Police Service and the Mines.

Pilot districts: These are the districts selected to test the effectiveness of the integration. The three districts are Mahalapye, Letlhakeng Sub-District and Kgatleng.

Health institutions: These include public (facilities as defined) and private health facilities and institutions

Non-health institutions: In this report they are institutions that do not operate as health institutions but offer health-related services and play complimentary roles to the health sector. They include government ministries and departments, private institutions, NGOs, CSOs and their umbrella institutions such as BOCAIP, BONASO, BONEPWA and BOCCIM.

vii.. THE GUIDING PRINCIPLES

The strategy development process benefited from two sets of guiding principles; the global standard⁶ and those developed through expert judgment approach at the Inception Reporting stage.⁷

a. Global principles:

- Address structural determinants: root causes of HIV & AIDS and SRH ill-health needs to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improved access to information and education opportunities.

⁴ People with Disability project under CDC/Government of Botswana 2005-2010 Mega Agreement on HIV/AIDS

⁵ Health Facilities by type and district sheet, MOH 2010

⁶ SRH and HIV/AIDS A Framework for Priority Linkages: WHO, UNFPA, UNAIDS, IPPF October 2005

⁷ Inception report and Consultation with UNFPA, MOH, NACA, WHO, UNICEF, BOFWA and BONEPWA

- Focus on human rights and gender: SRHR of all people including women and men living with HIV need to be emphasized as well as the rights of marginalized populations such as injecting drug users, men who have sex with men and sex workers. Gender sensitive policies to establish gender equality and eliminate gender based violence are additional requirements.
- Promote a coordinated and coherent response: promote attention to SRH priorities within a coordinated and coherent response to HIV&AIDS that builds upon the principles of one national HIV&AIDS framework, one broad based multi-sectorial HIV&AIDS coordinating body, and one agreed country level monitoring and evaluation system.
- Meaningfully involve PLWHA: women and men living with HIV&AIDS need to be fully involved in designing, implementing and evaluating policies, programmes and research that affect their lives.
- Foster community participation: young people, key vulnerable populations, and the community at large are essential partners for an adequate response to the challenges and for meeting the needs of affected people and communities.
- Reduced stigma and discrimination: more vigorous legal and policy measures are urgently required to protect PLWHA and vulnerable populations from discrimination.

b. Local Principles:

- Participation and consultation of stakeholders including CSOs, public and private institutions, development cooperation agencies, Users of the service, DHMTs, Service providers, Research institutions and Training institutions.
- The backing of relevant legal and policy documents, statements, conventions, global, regional and national goals
- Country-specific definitions of SRHR as clarified in the SRH Policies and Standards document
- Consensus on linkages and the integration package
- Strategy development which takes into account, the current situation and establish models that will be responsive to needs on the ground
- A collaborative strategy development which is health outcomes driven and recognizes the complimentary roles of both health and non-health institutions in the public and private sectors to realize improvement in current health outcomes relating to SRH and HIV&AIDS
- An implementation plan which is informed by the strategic objectives and recommendations.

1. EXECUTIVE SUMMARY

The Government of Botswana's SRH Policy Guidelines and Service Standards document provides the framework for developing a responsive strategy and an implementation plan for SRHR and HIV&AIDS Linkages and Integration. The global call on governments to demonstrate commitments to intensify linkages between sexual and reproductive health and HIV&AIDS at the policy and programme level is therefore an added opportunity for the government to review the current service provision model and optimize current resources to provide more integrated, comprehensive coordinated SRHR and HIV&AIDS services.

Three models⁸ namely 'kiosk', 'supermarket' and 'mall' were found as the mode through which moderate integrated services were being operated at various facility levels. The strategy will therefore ensure an enhanced integration which will be piloted in selected district health facilities in Kgatleng, Mahalapye and Letlhakeng sub-district in collaboration with CSOs, NGOs, Government ministries and departments from 2012 till 2014. The services will be guided by the identified SRHR and HIV and AIDS linkages listed below. After the pilot phase, an evaluation will be conducted to provide guidance for national implementation.

- Learn HIV status and access services
- Promote safer and healthier sex
- Optimize the connection between HIV and AIDS & STI service
- Integrate SRH weakest links
- Learn reproductive cancer status and access services
- Promote combination prevention
- Promote abstinence
- Integrate HIV and AIDS with ASRH
- Optimize connection between SMC and HIV

The first four linkages are adapted from the global framework while the remaining five are Botswana-specific. In order to provide the needed conducive environment, create and sustain demand for quality delivery of the integration the following strategies will be used: -

- Advocacy for legal, policy and programme development and sustainable funding
- Research, monitoring and evaluation including operations research, cost and benefit analysis, quality of care research and clinical trials, KAP studies to advance evidence-based programme development.
- Training including pre-service, in-service and sensitization of stakeholders including users/clients and the media
- Materials development including curriculum, guidelines, and IEC materials for service providers and users
- Integrated service provision at strategic locations within facilities such as ANC, PNC, FP, CWC, IDCC, pharmacy locations, doctors consulting rooms, Youth corners and clinics, private service providers locations
- Community mobilization in schools, Kgotla, homes, churches and mosques to create and sustain demand for services
- Strategic partnerships for resource mobilization, governance and quality assurance

The change expected in this renewed era of SRHR and HIV&AIDS integration is comprehensive service provision that is provided systematically and proactively to all clients/users in one location by skilled service providers to avoid missed opportunities and avert morbidity and deaths. The integrated service will be delivered by service providers from public health facilities. Non-health institutions such as CSOs, NGOs, government ministries and departments, the private sector and the media will play complimentary roles such as creating demand for service in communities and workplaces, reach the difficult to reach locations and targets, and advocate for policy and legal reform to provide the required enabling environment. This collaborative nature of the integration is one of the strengths of Botswana's integration strategy.

Integrated SRH and HIV&AIDS services will be provided to the entire population with due attention also to special population targets and vulnerable groups that require more dedicated attention such as people with disabilities, sex workers, young people including those who were born with the virus. At the preferred models in the health facilities, services will be provided at the same site on the same day.⁹ Service providers will be provided with additional skills where there are gaps to deliver the integrated services.

⁸ Descriptive terminology for different types of one stop service provision. See section on models

⁹ Rapid Assessment of SRH and HIV Linkages in Botswana 2008

A successful integration of SRH and HIV&AIDS at all levels is expected to contribute to the realization of the following health outcomes but not limited to: -

- Reduction in new HIV infections
- Increase in male involvement
- Reduction in gender based violence
- Reduction in unsafe abortions
- Reduction in maternal mortality
- Reduction in mother to child transmissions
- Increase in voluntary couples HIV counseling and testing
- Increase uptake of SMC
- Reduction in neo-natal and infant deaths

A strong monitoring and evaluation framework to offer strategic guidance ensuring continuous tracking of implementation and goal attainment is essential. The project monitoring and evaluation system will espouse the principles of integration and seek to harmonize the different programmatic indicators, reduce fragmentation and avoid redundancies. Furthermore, this will form the basis for a systematic documentation of lessons learnt to guide future scale-up efforts.

2. INTRODUCTION AND BACKGROUND

Integrating SRHR and HIV&AIDS linkages at health and non-health institutions and facilities in Botswana constitutes an additional and major landmark in the country's efforts at revitalizing its commitment to providing quality of care. In the past few decades, Botswana has been signatory to global and regional conventions and agendas on health¹⁰.

Since the advent of HIV&AIDS however, the majority of these conventions and agendas have called attention on governments to speed up actions on addressing the HIV&AIDS epidemic given its critical nature. Relevant examples in this context include, the 2005 Continental Policy Framework on the promotion of SRHR in Africa, the Maputo Plan of Action 2006, the Abuja call for accelerated action towards universal access to HIV&AIDS, Tuberculosis and Malaria services in Africa 2006, the Africa Health Strategy 2007, the International consensus on the MDGs and the target set for universal access to reproductive health and the AU campaign on accelerated reduction of maternal mortality (CARMMA) 2009¹¹.

The call for integration is primarily based on the Maputo Plan of Action¹² as it was intended to be a roadmap for member states in achieving the AU policy framework for promotion of sexual and reproductive health and rights in Africa. The plan focuses on the following areas:

- Integration of Sexual and Reproductive Health (SRH) services into primary health care,
- Repositioning family planning,
- Developing and promoting youth friendly services,
- Unsafe abortion
- Quality safe motherhood
- Resource mobilization
- Commodity security and
- Monitoring and evaluation.

In response, the Government of Botswana's National Development Plans, Vision 2016, health and HIV&AIDS policies and their corresponding strategic frameworks have been major vehicles for elaborating steps towards the achievement of these goals. In particular, the Policy Guidelines and Service Standards of the Ministry of Health on SRH¹³ articulate the importance of SRHR and HIV&AIDS linkages and the impact that can be derived from their integration in service delivery. The two tables below contain a list of the prescribed SRHR and HIV&AIDS services in Botswana.

Table 1: SRH components

| Sexual and Reproductive Health Services |
|--|
| Adolescent Sexual and Reproductive Health, Family planning, Safe Motherhood Initiative, Sexually Transmitted Infections including HIV/AIDS, Prevention of Mother To Child Transmissions, Antiretroviral Therapy, IPT, Voluntary Counseling and Testing, Gender-Based Violence, IEC and BCIC, Fertility Management, Infertility and Sexual Dysfunction, Cancers of the Reproductive System, Male Involvement, Maternal and New-born Care, Antenatal Care and post natal care, Preconception Care, Post-natal Care, Emergency Obstetric Care, Labor and Delivery and Post Abortion Care. |

Table 2: HIV&AIDS components

| HIV/AIDS Services |
|--|
| Safe Male Circumcision, Routine HIV Testing, HIV Counseling and Testing, Couples HIV/AIDS Counseling and Testing, PMTCT, BCIC, ART, IPT, TB screening, reproductive tract cancer screening, home-based care and psychosocial support to the infected and affected, care and support, prevention for and by people living with HIV, HIV prevention to the general public, Prophylaxis and treatment for people living with HIV (opportunistic infections), PITC (provider and client-initiated testing and counseling). It involves the routine offer of HIV testing to all patients in health care settings where HIV is prevalent and anti-retroviral treatment is available. It includes client initiated as well, Prevention for and by people living with HIV and prevention for the general population, Male and female condom provision and specific services for key populations. |

¹⁰ See list of global and regional agendas in Annex 1

¹¹ CARMMA, Africa cares: No Woman Should Die While Giving Life

¹² Southern Africa HIV and AIDS Information Dissemination Service

¹³ Policy Guidelines and Policy Standards: Sexual and Reproductive Health, Ministry of Health Department of Public Health

The justification for the integration include the evidence that the majority of HIV infections are sexually transmitted or associated with pregnancy, child birth and breast feeding and the interactions between them are widely recognized. In addition, sexual and reproductive ill health and HIV&AIDS share root causes including poverty, gender inequality and social marginalization of the most vulnerable populations. The international community agrees therefore that the MDGs will not be achieved without ensuring access to SRH services and an effective global response to HIV&AIDS.¹⁴ It is hypothesized therefore that stronger linkages between SRH and HIV&AIDS programmes should lead to a number of important public health benefits. Much remains unknown however, about which linkages will have the greatest impact and how best to strengthen selected linkages in different programme settings. With careful priority setting and judicious programme implementation, the following benefits are expected to be derived:¹⁵ -

- Improved access to and uptake of key HIV&AIDS and SRH services
- Better access of people living with HIV&AIDS to SRH services tailored to their needs
- Reduced HIV&AIDS related stigma and discrimination
- Improved coverage of underserved and marginalized populations, such as injecting drug users, sex workers or men who have sex with men with SRH services
- Greater support for dual protection against unintended pregnancy and sexually transmitted infection including HIV, for those in need, especially young people.
- Improved quality of care
- Enhanced programme effectiveness and efficiency

A Rapid Assessment of SRH and HIV&AIDS Linkages¹⁶ in Botswana found the existence of bi-directional linkages. Although their integration at the facility level was neither systematic¹⁷ nor comprehensive, the integration of HIV and AIDS components into SRH was better than SRH into HIV and AIDS. However, the Assessment reported better intra HIV and AIDS linkages and their integration at all facilities visited than intra SRH linkages and their integration.

The conclusion of the Assessment from the viewpoint of clients/users of the service was to have linked services at one point instead of having to make repeated visits or wait in long and different queues at different locations in the same facility or by travelling long distances for them.

The results of such situations are that clients get discouraged and therefore do not follow through to obtain remaining and critical services they require and in the process may contract other diseases or even die from delayed attention. How to prevent missed opportunities through proactive and preventive care and to provide comprehensive curative care is the premise for integration in Botswana. This is clearly articulated in the SRH Policy Guidelines Service Standards as quoted below:-

From the client's viewpoint- the different SRH services corresponding to stages in the life cycle should be conveniently available at the same or in linked institutions. For example, a recently delivered mother should be able to have a post natal check-up for herself, immunization for her infant, and advice on breastfeeding as well as contraceptive services without having to make repeated visits for each. Another example would be a woman found to be ineligible IUD insertion on account of RTI (reproductive tract infection) should simultaneously receive treatment for the infection. Male clients should have access to contraception, RTI/STD services and counseling for sexual dysfunction in one venue or at a functional two way referral system.¹⁸

The latest Botswana MDG status report¹⁹ indicated a mix of successes regarding MDG 4, 5 and 6²⁰. While three of the indicators which measure a reduction in child mortality, estimated under five mortality as 57 per 1000 births in 1990 and 76 per 1000 births in 2007, the proportion of one year old children immunized against measles increased from 45 (per 1000 deaths) in 1990 to 90 in 2007. There was a strong correlation between the impact of births attended by skilled health personnel and maternal mortality because when births attended to by skilled personnel increased from 77% in 1990 to 94.6% in 2007, maternal mortality rates decreased from 326 (per 100 000 population) in 1990 to 183 in 2007. On the HIV&AIDS front, the HIV&AIDS prevalence among 15-19 year old pregnant women decreased from 22.8 in 2003 to 17.2 in 2007. The prevalence among 20-24 year old pregnant women also decreased from 38.6% in 2003 to 31.2% in 2007. Contraceptive rate of all women aged 15-49 years increased from 40% to 52.8%. Additional indicators include 90% of one year old children immunized, less than 4% of children born to HIV infected mothers are infected. Neonatal deaths are at 35 per 1000 births.

¹⁴ (Sexual and Reproductive Health and HIV/AIDS: A Framework for Priority Linkages. 2005).

¹⁵ *ibid*

¹⁶ Rapid Assessment of Sexual and Reproductive Health and HIV&AIDS Linkages in Botswana, 2008

¹⁷ A collaborative study conducted by the Departments of Public health and HIV/AIDS Prevention and Care, MOH, GOB, WHO(Gaborone and Geneva and UNFPA Gaborone)

¹⁸ National Sexual and Reproductive Health Programme Framework: Ministry of Health 2002

¹⁹ Source: Botswana Central Statistical Office 2010 and World Bank Development Indicators 2009

²⁰ MDG 4: Reducing child mortality rates; MDG 5: Improving maternal health; MDG 6: Combating HIV/AIDS, malaria and other diseases

Given the current status of reproductive health of the population, the current emphasis on proactive preventive and comprehensive care is justified. 90% and 93% of children were fully immunized by one year of age in 2007 and 2009. Following an improvement in the maternal mortality monitoring system, Botswana experienced an increasing trend from 193 to 198 in 2007 and 2008 respectively. Knowledge of family planning is nearly universal with 98.3% of all women aged 15-49 and 96.8% of all men aged 15 to 49 knowing at least one method of family planning in 2007. 90% of HIV infected pregnant women access PMTCT which has led to a reduction of mother to child transmission from 40% to 4% in 2007. There are clearly missing gaps given the entire prescription of SRH services in the country. These missing gaps include the SRH requirements for men, youth and the aged population. These gaps further justify the need for linked services delivered in an integrated manner.

On the HIV&AIDS front in Botswana, given that the epidemic moved swiftly through phases of low grade epidemic, through concentrated epidemic to generalized and now stands at hyper-endemic epidemic, efforts at combating it had to be vertical, focused and concentrated. These efforts have yielded positive results including averting 53,000 deaths through the provision of ART between 2000 and 2007²¹. Number of deaths among children 15 years and below also decreased mainly due to the success of PMTCT over the same period which also gave rise to the decline in the number of newly infected children less than 15 years from 4,082 in 2001 to 1,074 in 2007 and 886 in 2009. A total decline of 78% over 8 years! Despite these gains, the HIV prevalence stands at 17.6% (one of the highest in the world) and the incidence is 2.9%.

The global clarion call provides a refreshing opportunity for governments to take action to reverse and halt negative impacts associated with the epidemic.

A major call in this context of integration was the International Conference on Population and Development (ICPD) in 1994 and subsequent roadmaps that introduced a paradigm shift from a demographically-driven focus on family planning to a health-driven focus on sexual and reproductive health (SRH). This shift in particular established an SRH approach that is comprehensive and integrated as it addressed the essential needs of individuals throughout the life cycle. WHO's public health approach to scaling up HIV&AIDS services towards universal access has as one of its pillars decentralization and integration of health services²². It calls for the integration of HIV with other priority health interventions as key challenges for achieving universal access. There is also the call on the international community to intensify linkages between SRH and HIV&AIDS at the policy and programme level as expressed in the June 2005 UNAIDS policy position paper "intensifying HIV prevention" This builds on the New York Call to Commitment: "Linking HIV&AIDS and Sexual and Reproductive Health and the Glion Call to Action on Family Planning and HIV&AIDS in women and children". These policy statements call on both the SRH and HIV&AIDS communities to strengthen programmatic linkages between SRH and HIV&AIDS²³

Given the Government's endorsement of these approaches, the Ministry of Health's policy and service standards set the goal of improving the sexual reproductive health of all people living in Botswana through nine specific objectives. These are to:-

- Improve understanding of SRH by parents, children and youth
- Improve ASRH and youth health
- Reduce maternal and perinatal morbidity and mortality
- Enhance gender equality and equity
- Control STI and HIV&AIDS
- Meet family planning needs
- Prevent and manage infertility, reproductive tract cancers and mid-life concerns
- Ensure national capacity to conduct operations research and manage functional health information system

These policy guidelines and service standards render HIV&AIDS an integral part of sexual reproductive health rights. The rights approach derives from fundamental human rights and freedoms that are enshrined in the constitution of Botswana and included in the global agreements and agendas referred to earlier.

In this regard, the basic right of couples and individuals to attain the highest standards of sexual and reproductive health and to decide freely (without discrimination, coercion or violence) and responsibly the number and the spacing of their children and to have access to information and education to make informed choices and the means to do so is upheld.

²¹ Modes of Transmission study, Botswana Synthesis report: mathematical modeling by Stower et al (2009)

²² HIV/AIDS Programme, Towards Universal Access by 2010: How WHO is strengthening health services to fight HIV/AIDS. World Health Organization, 2006.

²³ Sexual and Reproductive health & HIV/AIDS A Framework for priority Linkages

In addition, quality of SRH services is regarded as a right of everyone. The SRH rights also recognize the needs of service providers because of their importance in ensuring SRH rights. Client rights and provider needs as contained in the policy guidelines anchor the essence of quality of care. Ensuring client rights and provider needs are therefore the recognized means of ensuring quality of health delivery which captures the vision and mission of the Ministry of Health²⁴.

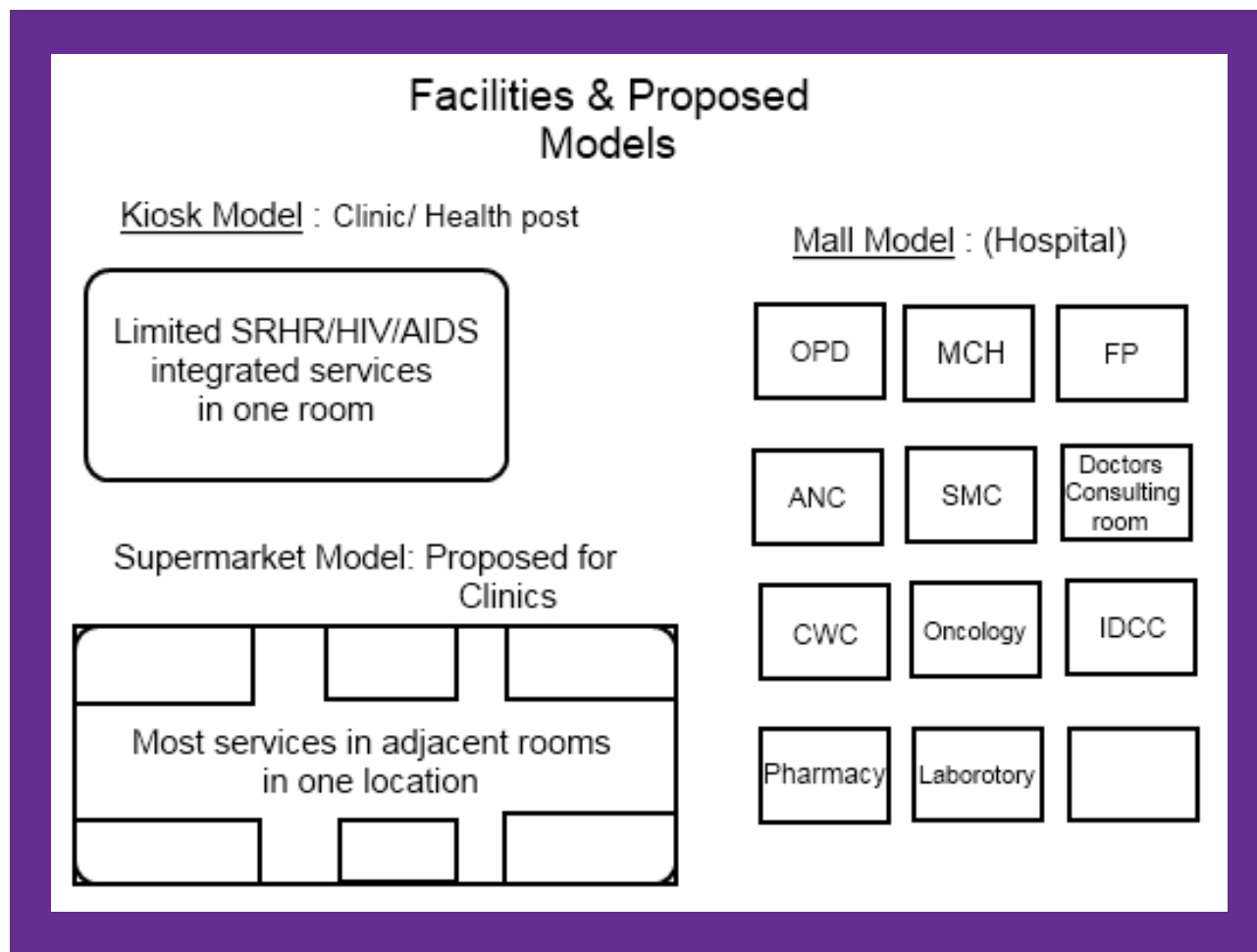
The SRHR strategy which follows next was informed by a collection of data as directed by the methodology selected for strategy development. These are as listed and can be found in the annex. They are: The methodology, Situational analysis, the project's log-frame, the tool for data collection, list of consultations, documents consulted and global and African Conventions and Treaties that Botswana may be signatory to attached as annexes such as the information methodology in annex one document is in two parts.

²⁴ Policy Guidelines and Service Standards: Sexual and reproductive health. Ministry of Health.

3. PROPOSED MODELS FOR INTEGRATION

The 3 models as shown below will be piloted in the three pilot districts. Human resource, supplies and equipment needs will be determined and provided for the pilot. Lessons learned in this process will then be as input for replicating these models during the national scale up.

Diagram 1: Proposed models for the integration



3.1 The Mall model

This will be operated at the district and primary and referral hospitals. This is where specialized services are provided. Service providers will be required to provide comprehensive service based on guidelines for linkages and integration. Additional skills for service providers are envisaged and these will be provided progressively.

3.2 The supermarket model

This will be operated at clinics; with and without maternity. The IDCC's and Youth friendly service corners in facilities will also operate this model. Their human resource, equipment and supplies needs will be assessed and provided accordingly.

3.3 The kiosk model

Health posts are generally limited by space and personnel. Given this limitation, the kiosk model best fits the arrangement for integration. Additional space in the form of porter cabins will have to be procured for the pilot sites. Similar arrangements will have to be made for mobile stops in order to facilitate integration. In particular there will be the need to consider the purchase of mobile vans.

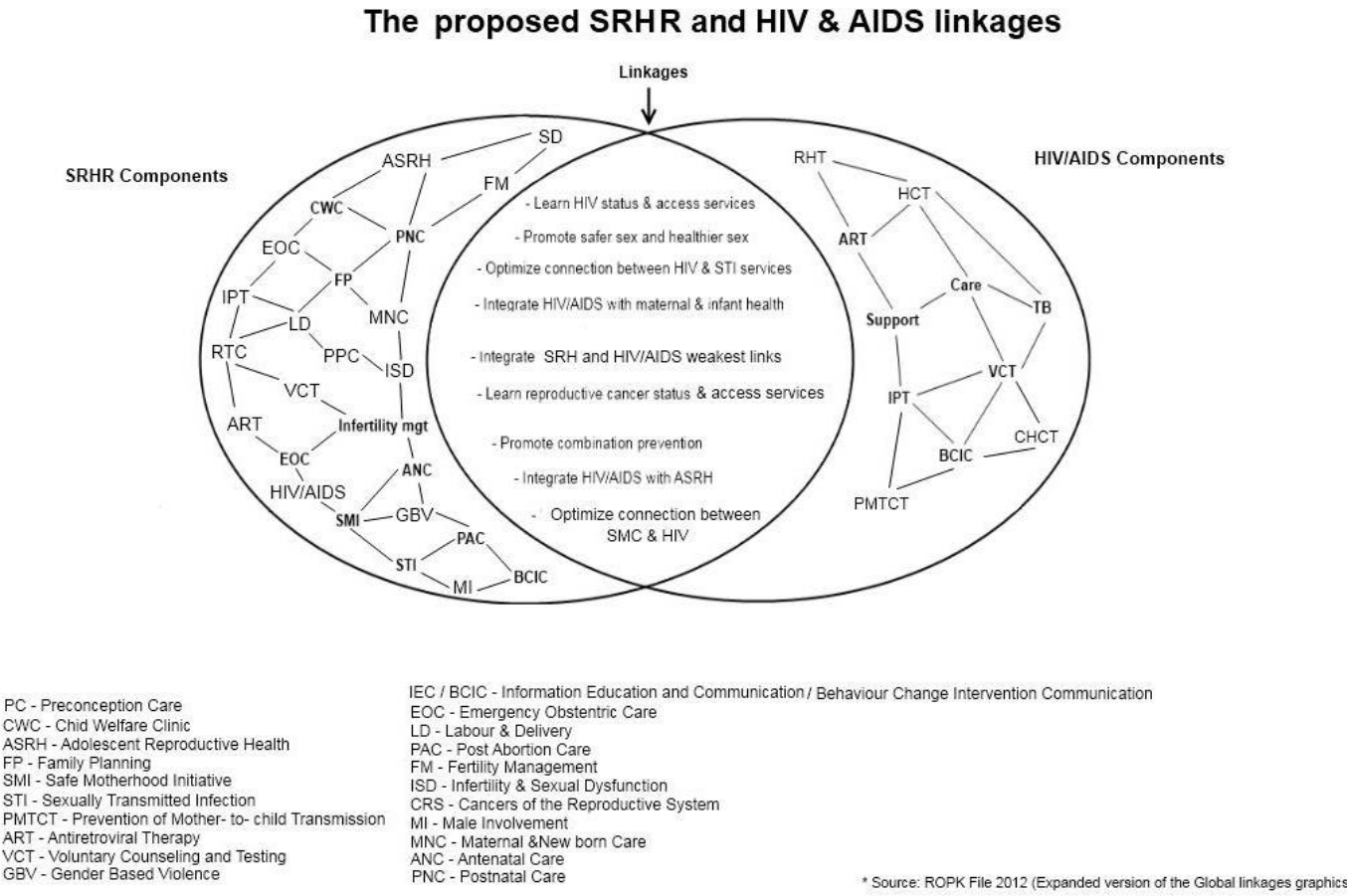
The change expected in the era of integration is that service providers will no longer use their 'discretion' but will follow prescribed integration guidelines to deliver proactive, preventive and curative service to all SRHR and HIV clients. The intention of the integration is for all clients to obtain all the integrated services whether they were referred or are first time clients in any of the facilities. SRH and HIV locations within the hospital will provide complete integrated service to all clients (ref. linkages and integration package). This is to avoid missed opportunities for reducing morbidity and mortality and to improve health outcomes.

4. THE PROPOSED SRH AND HIV AND AIDS LINKAGES

In order to fill the gaps identified by the Rapid Assessment Report, the proposed linkages which are derived from the entire spectrum of SRHR and HIV&AIDS preventive and curative services will guide the integration. These are the proposed priority areas identified where linkages are likely to lead to important public health benefits and constitute the framework for the integration of SRHR and HIV&AIDS at all levels; health and non-health institutions (both private and public). The involvement of private hospitals and clinics will however require sustained Ministry of Health's advocacy and support. Their roles need to be clarified. In addition, they will have to be trained and be provided with resources such as information in a sustained manner.

These linkages are also the basis for deriving the strategic objectives and actions and implementation plans that are elaborated later in the document.

Diagram 2: Proposed linkages



4.1 The proposed models and locations for the integration

From the preferred service provision models (clarified under section 3 of this document), service providers from public facilities will provide integrated SRH and HIV and AIDS services from specified locations including: -

- (a) IDCCs
- (b) ANC, PNC
- (c) CWC
- (d) Pharmacies
- (e) Doctors consulting rooms
- (f) OPDs
- (g) Youth corners

4.2 SRH goals and the linkages for integration

The 8 linkages below are those identified to correspond to the 8 goals of SRH in the country

4.2.1 Learn HIV status and access services

4.2.2. Promote safer sex and healthier sex

4.2.3 Optimize connection between HIV and STI services

4.2.4 Integrate HIV and AIDS with maternal and child health

4.2.5 Integrate SRH and HIV and AIDS weakest links

4.2.6 Learn reproductive cancer status and access services

4.2.7 Integrate HIV with ASRH services

4.2.8 Optimize connection between SMC and HIV

These linkages are developed around the 8 national goals of SRH listed below²⁵. These will guide comprehensive service provision in an integrated manner from the identified locations listed at 4.1. The delivery of these integrated services will be guided by the linkages and will contribute to the realization of these goals: -

- Improved understanding of SRH by parents, children and youth
- Improved ASRH and youth health
- Reduced maternal and perinatal morbidity and mortality
- Enhanced gender equality and equity
- Controlled STI and HIV&AIDS
- Provision of family planning needs
- Prevention and management of infertility, reproductive tract cancers and mid-life concerns
- Ensured national capacity to conduct operations research and manage functional health information system

4.3 The linkages, proposed locations and models

| LINKAGES | PROPOSED SRH or HIV and AIDS LOCATIONS WITHIN FACILITIES | PROPOSED MODELS THAT WILL OPERATE THE INTEGRATED SERVICE |
|---|---|---|
| Learn HIV status and access services | IDCC, ANC/PNC, Youth corners, Doctors consulting rooms, OPDs, CWCs | All models |
| Promote safer sex and healthier sex | IDCC, ANC/PNC, Youth corners, doctors consulting rooms, youth corners, CWCs | All models |
| Optimize connection between HIV and STI services | IDCC, ANC/PNC, youth corners, | All models |
| Integrate HIV and AIDS with maternal and child health | IDCC, ANC/PNC, CWCs, Youth corners | All models |
| Integrate SRH and HIV and AIDS weakest links (e.g infertility management, gender violence..) ¹ | IDCC, youth corners, doctors rooms | Mall and supermarket models |
| Learn reproductive cancer status and access services | IDCC, ANC/PNC, doctors rooms, youth corners | All models |
| Integrate HIV with ASRH services | Youth corners, doctors rooms, | Mall with the youth friendly service spots. clinics and health posts with access to porter cabins |
| Optimize connection between SMC and HIV | Youth corners, IDCC, doctors rooms, SMC surgery rooms | Mall |

²⁵ Policy Guidelines and Service Standards, SRH (MOH)December 2004

Generally, the capacity for educating and informing users about integrated service, its benefits and accessibility will be done at both facility levels and in communities. Health Education cadres of public and private health providers will collaborate with NGOs, CSOs and civil society organizations in this regard. Referrals outside the facility/location will only be done when the service is specialized and cannot be provided at the particular facility.

5. STRATEGIC OBJECTIVES AND ACTIONS

Strategic actions which will be required to ensure the smooth implementation of the integration include: -

5.1 Advocacy and policy dialogue

Key advocacy and policy dialogues have been identified in the area of policy reviews, sustainable funding and to ensure the participation of the private health sector.

5.2 Research, monitoring and evaluation

To ensure evidence-based programme development and utilization of operations research, research, monitoring and evaluation have been identified as key to strengthen the integration process

5.3 Training

Training is very important for delivering quality integration. Key personnel to be trained are health providers. Training and educational institutions will collaborate with the Ministry of Health to ensure curriculum review and development to take account of the linkages.

5.4 Service provision

Integrated services will be provided at the identified strategic locations within various public facilities as well as in private facilities.

5.5 Community mobilization

Community mobilization will ensure that communities are mobilized to access the integrated services. Community strategies available to the health providers such as the HEAs and Lay Counselors and the machineries of CSOs, NGOs, CBOs will be used to create the demand for integrated services.

5.6 Resource mobilization

The required resources will ensure that the integration is funded optimally for the provision of resources including equipment, medical supplies and human resources

5.7 Strategic partnerships

SRHR and HIV&AIDS linkages require a multi-sectoral approach. Establishing and maintaining strategic partnerships is therefore very crucial to the success of the integration. These partnerships will include development partners, CSOs, NGOs, CBOs, and the media among others.

5.8 Governance

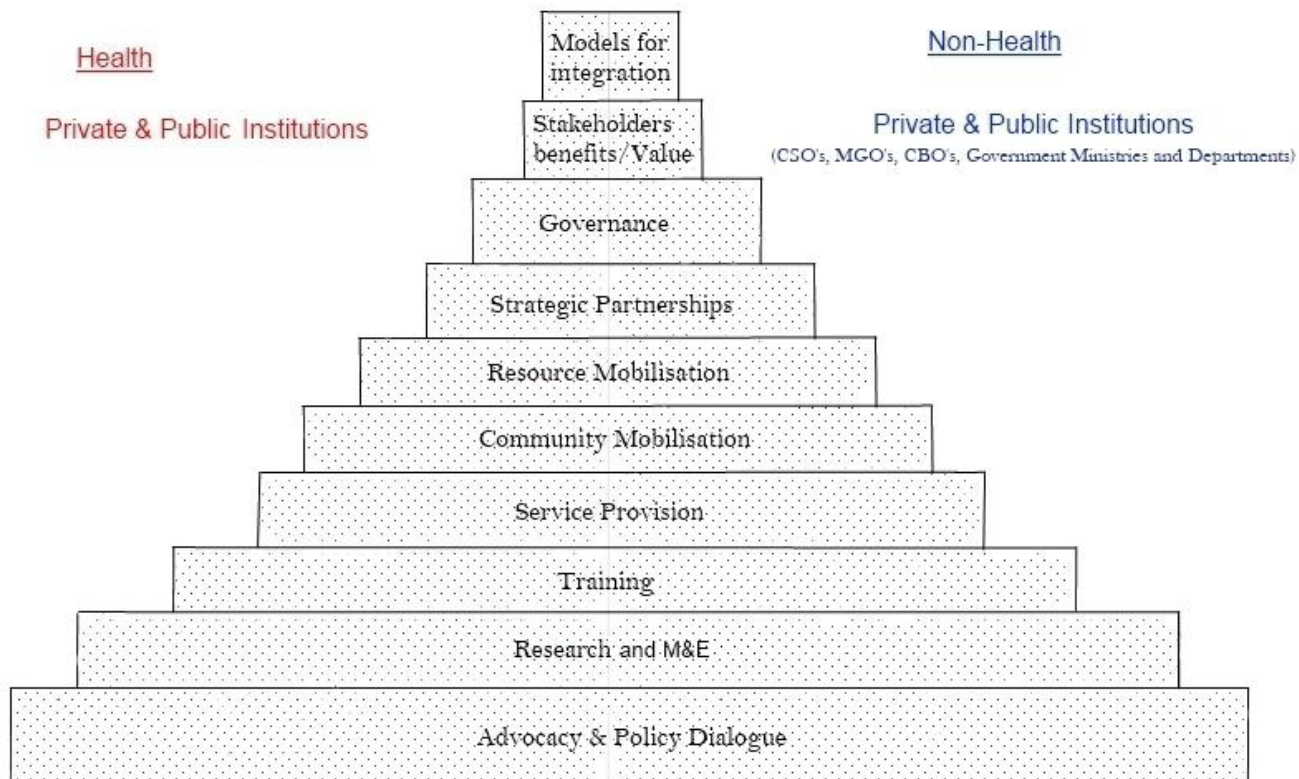
Efficient governance arrangements at all levels will ensure responsibility and accountability for the integration. The governance structure is provided in Section 9. The structure will ensure that key stakeholders such as MOH and DHMTs play their roles for smooth implementation and account to respective bodies. The respective governance roles are delineated.

5.9 Managing stakeholders benefits

Stakeholders' benefits will have to be managed systematically in order for them to be realized. These benefits were identified during the consultations. Their realization is a function for the success of the integration.

The effective utilization of these strategies will ensure a successful integration and sustainability of the SRHR and HIV & AIDS integration.

Diagram 3: Strategic objectives and actions building blocks



6. LINKAGES AND STRATEGIC OBJECTIVES

Table 3: PROPOSED LINKAGES AND STRATEGIC OBJECTIVES AND ACTIONS SUMMARY SHEET

| LINKAGES | | | | | | | | | | | |
|----------------------------|--------------------------------------|---------------------------------|---|--|--|-----------------------------|----------------------------------|--------------------------------|--------------------|------------------------------|--------------|
| GLOBAL | | | | | NATIONAL | | | | | | |
| Strategic Objectives | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/AIDS & STI Services | Integrate HIV/AIDS with Maternal and Infant Health | Optimize the complementary role of the non-health sector | Integrate SRH weakest links | Learn reproductive cancer status | Promote combination prevention | Promote abstinence | Integrate HIV/AIDS with ASRH | Stakeholders |
| Advocacy & Policy dialogue | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Research | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Training | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Services | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Community Mobilisation | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Strategic partnerships | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

The linkages, strategic objectives and actions summary sheet above provides a snapshot view of the linkages and the strategic objectives. It also demonstrates that each of the identified strategies is needed to intervene at each of the identified SRH and HIV&AIDS linkage. Their priority ratings are shown and explained at the rated Linkages and strategic objectives tables and the strategic framework section below.

6.1 THE SRH AND HIV AND AIDS LINKAGES AND STRATEGIC OBJECTIVES MATRIXES

The matrixes below are informed by the situation analysis for the strategy development. The priority ratings are for the purpose of gauging the implementation of the strategic actions. A rating of high priority means there is need to fill critical gaps in accessibility and availability or action. Medium priority implies the gaps are not so critical because the service or actions may be available and accessible but there is room for improvement. Low priority means there are few critical gaps to be filled because services or actions are adequate.

Objective: To strengthen advocacy interventions in order to enhance the legal and policy environment for efficient programme development, research, sustainable funding, and the participation of the private health practitioners.

Table 4: Advocacy matrix

KEY: HIGH PRIORITY ■ MEDIUM PRIORITY ■ LOW PRIORITY ■

| LINKAGES | | | | | | | | |
|-----------------------------------|--------------------------------------|---------------------------------|---|--|--|----------------------------------|--------------------------------|------------------------------|
| Strategic Objectives- ADVOCACY | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/AIDS & STI Services | Integrate HIV/AIDS with Maternal and Infant Health | Integrate SRH and HIV/AIDS weakest links | Learn reproductive cancer status | Promote combination prevention | Integrate HIV/AIDS with ASRH |
| Legal | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Policy | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Programme | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Funding | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Research | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Private sector health providers | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |

Advocacy interventions required to be undertaken towards the success of SRHR and HIV&AIDS integration will be done around legal, policy, programme and sustainable funding challenges. From the table legal advocacy seems to be low priority while policy, programme and funding advocacy are of high priority for the integration to be successful.

Table 5: Research, M&E matrix

Objective: To provide research evidence for implementation, monitoring and evaluation

| LINKAGES | | | | | | | | |
|---|--------------------------------------|---------------------------------|---|--|-----------------------------|----------------------------------|--------------------------------|------------------------------|
| Strategic Objectives- RESEARCH, M&E | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/AIDS & STI Services | Integrate HIV/AIDS with Maternal and Infant Health | Integrate SRH weakest links | Learn reproductive cancer status | Promote combination prevention | Integrate HIV/AIDS with ASRH |
| Operations Research | | | | | | | | |
| Cost & Benefit Analysis | | | | | | | | |
| Quality of Care dimensions of users and providers | | | | | | | | |
| Clinical Trials | | | | | | | | |
| Empirical Research | | | | | | | | |
| M&E | | | | | | | | |

Five areas of research will contribute to making the integration evidence-based and qualitative. Operations research, cost and benefit analysis and quality of care studies, and partnerships for research stood out as high priority. An examination of research agendas of NACA and MOH pointed to gaps in operations research in particular. Cost and benefit analysis will be needed from the outset (as pre-requisite) for this endeavour. Quality of care dimensions of care givers and clients will be needed to enhance the delivery of their expectations. For instance, BHP is undertaking various and relevant clinical trials that the integration will benefit from the reason its rating are low priority. In addition, CDC is engaged in a KAP (Knowledge, Attitude and Practice) study to improve PMTCT. These are key initiatives that the integration will benefit from.

Monitoring and evaluation is high priority. A creative way of minimizing the multiple registers has been raised. The conclusion is that PIMS II should be expedited where IPMS is not in operation.

Table 6: Training matrix

Objective: To enhance the capacity of institutions and service providers of health and education to support the integration at all levels.

| | | LINKAGES | | | | | | | |
|---|--------------------------------------|---------------------------------|--|---|-----------------------------|----------------------------------|--------------------------------|-------------------------------|--|
| Strategic Objectives- TRAINING | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/ AIDS & STI Services | Integrate HIV/ AIDS with Maternal and Infant Health | Integrate SRH weakest links | Learn reproductive cancer status | Promote combination prevention | Integrate HIV/ AIDS with ASRH | |
| Pre-Service Training (educ.) | | | | | | | | | |
| In-service (educ.) | | | | | | | | | |
| Pre-Service (health) | | | | | | | | | |
| In-service (health) | | | | | | | | | |
| Materials Dev. (health) | | | | | | | | | |
| Materials Dev. (educ.) | | | | | | | | | |
| Public Sector non-health e.g Ministries, men and women sector | | | | | | | | | |
| Private Sector non-health | | | | | | | | | |
| Private sector and quasi govt. health inst. | | | | | | | | | |
| BOCAIP BOFWA and Tebelopele | | | | | | | | | |
| The media | | | | | | | | | |

Training will constitute the backbone for the integration as such training institutions of both health and education are very important stakeholders considering the reach of teachers to young people in the country and health workers' role at the facilities. The table indicates low priority for in-service training of Teachers and health providers. This rating shows that training is going on generally however there is need to have a more focused SRH and HIV&AIDS integration package infused in the training curricula. Pre-service training curricula changes will create a more lasting effect on the integration. The I.H.S and the UB Nursing School will make room in their curricula review occurring in May/June to incorporate topics on the linkages. The public sector non-health institutions are rated medium because they have the ministerial HIV&AIDS and wellness coordinators who will require to be given orientation to include the linkages requirements in their curricula. The Men and Women sector HIV&AIDS committees will require similar orientation and training.

Similarly, non-health institutions in the private sector will need training and orientation.

Table 7: Service provision matrix

Objective: To provide SRHR and HIV&AIDS integrated services at identified locations in health facilities.

| LINKAGES | | | | | | | | |
|-----------------------------------|--------------------------------------|---------------------------------|---|--|-----------------------------|----------------------------------|--------------------------------|------------------------------|
| Strategic Objectives-SERVICES | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/AIDS & STI Services | Integrate HIV/AIDS with Maternal and Infant Health | Integrate SRH weakest links | Learn reproductive cancer status | Promote combination prevention | Integrate HIV/AIDS with ASRH |
| ANC/PNC/FP Locations | Light | Light | Light | Light | Dark | Dark | Dark | Light |
| CWC | Light | Dark | Dark | Dark | Dark | Dark | Dark | Dark |
| IDCC | Light | Light | Light | Dark | Dark | Dark | Dark | Dark |
| Pharmacies | Light | Light | Light | Dark | Dark | Dark | Dark | Dark |
| Doctor's Consulting Room | Light | Light | Light | Light | Dark | Dark | Dark | Dark |
| Youth Corners/Clinics | Light | Light | Light | Light | Dark | Dark | Dark | Light |
| Private service providers | Dark | Dark | Dark | Dark | Dark | Dark | Dark | Dark |
| BOFWA/BOCAIP/Tebelepele | Light | Light | Light | Dark | Dark | Dark | Dark | Dark |
| Quasi-govt. clinics and hospitals | Light | Light | Light | Dark | Dark | Dark | Dark | Dark |

Service provision is very critical for delivering the facility-specific integration. The areas demarcated under the strategic objectives and actions are not exhaustive however from the consultations these are the key focal points where SRH and HIV&AIDS integration can occur. It is notable although understandable that with the exception of the private sector hospitals RHT is provided. All the linkages require high priority attention by the private sector hospitals. It is again envisaged that the advocacy will yield positive results for them to be engaged meaningfully and systematically. Each of the focal points for integration at the facility level will require different mixes of approaches depending on what the DHMTs choose. IDCCs will require more infusion of SRH. Their Pharmacies will explore integrating SRH drugs. Better forecasting will be required to avoid stock-outs.

Task shifting is envisaged for instance for the HEAs who have first contacts with mothers at the CWCs. As previously noted, they will need additional knowledge and skills to inform and direct mothers to appropriate points in the same location for additional SRH and HIV services. In addition, as learned from the Kenya and Ethiopia success stories, HEAs may be provided with referral forms to be used during home visits.

Youth corners need to be provided with the required equipment and supplies. Appropriate space will be required by health posts in particular to provide youth friendly services. In addition, service providers will need training to provide youth friendly services. Comprehensive resource requirements are expected to be developed by DHMTs.

BOFWA, BOCAIP and Tebelopele will require renewed support in order to be engaged fully. Looking at the table, there are linkages gaps in their delivery which must be filled in view of their potential in delivering complimentary services to the health facilities particularly to young people.

Table 8: Community mobilization matrix

Objective: To inform and educate pilot communities about the importance of the integration and availability of integrated services in the selected pilot districts.

| LINKAGES | | | | | | | | |
|--|--------------------------------------|---------------------------------|---|--|-----------------------------|----------------------------------|--------------------------------|------------------------------|
| Strategic Objectives- Community Mobilisation | Learn HIV Status and Access Services | Promote Safer and Healthier Sex | Optimize the Connection between HIV/AIDS & STI Services | Integrate HIV/AIDS with Maternal and Infant Health | Integrate SRH weakest links | Learn reproductive cancer status | Promote combination prevention | Integrate HIV/AIDS with ASRH |
| Kgotla | | | | | | | | |
| Homes | | | | | | | | |
| Community -schools | | | | | | | | |
| Churches/ Mosques | | | | | | | | |

Gaps in community mobilization should be provided by HEAs, Peer mothers, support groups, Lay Counselors and Priests of churches and mosques by providing them with the needed skills and knowledge. For the integration to be well received, sensitization will have to be done at the Kgotla, during home visits by the HEAs, Peer mothers and Lay Counselors. Priests and teachers also occupy very strategic positions in the communities. Providing them with the requisite information will enhance their role as information givers and agents of change.

Summary

Overall, the global linkages are the most known and delivered in the country even though not systematically. The public facilities compared to the private are those delivering these linked services (the first 4). Among the global linkages, 'Learn status and access services is the most delivered. The country-specific linkages are yet to be tested while the global linkages get improved.

7. THE IMPLEMENTATION PLAN

The project's log frame obtainable from MOH provides the overall guide for implementation. The implementation plans below is therefore additional and are related to this strategy. They delineate additional activities for the pilot and some preparatory activities for the national scale-up. District needs are partly covered in this section and partly in the project's log frame for which financial support is already obtained. Sensitization of stakeholders at national and district levels will be done before the pilot takes off.

Table 9: Advocacy implementation plan

| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | | | | |
|---|---|------|---|---|---|------|---|---|---|-----------------|---|---|---|---|---|----------------------|----------------------|---|-----------------------------------|
| ADVOCACY | <ul style="list-style-type: none"> Operational TAC and RC Financial Commitments from funders Positive response from the private sector health institutions | | | | | | | | | | | | | \$ () additional to the EU funds for the pilot and beyond | Advocacy will be successful to secure additional funds and to engage the private sector | | | | |
| | | | | | | | | | | | | | | Revised HIV/AIDS National Strategic Framework and MOH SRH Policy and Standards document | | | | | |
| Activities | PILOT PHASE 2012-2014 | | | | | | | | | | | | | Est. Cost (Pula) | Mon. Indicators | Responsibility | | | |
| | 2012 | 2013 | | | | 2014 | | | | 2015 and beyond | | | | | | | | | |
| Advocate for sustainable funds | | x | x | x | x | x | X | x | x | x | x | x | x | x | x | x | No cost is envisaged | 3 meetings of TAC and 2 meetings of RC a year | MOH, NACA, Integration TAC and RC |
| Advocate for inclusion of the private health sector in the programme. | | x | x | x | x | x | X | x | | | | | | | | | | | |
| Advocate for review of Policies and strategies | | x | x | x | | | | | | | | | | | | No cost is envisaged | | | |

Table 10: Research, M&E implementation plan

| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | | | | |
|--|---|---|---|------|---|---|---|------|---|---|-----------------|---|---|---|------------------------------------|----------------|-----------|--|-----|
| RESEARCH, MONITORING AND EVALUATION | <ul style="list-style-type: none"> Operations research and clinical trials topics Commissioned researches and clinical trials | | | | | | | | | | | | | Research papers and results of trials Utilization of results for the national scale-up | Relevant topics will be identified | | | | |
| Activities | Pilot 2012-2014 | | | | | | | | | | | | | Est. Cost (Pula) | Mon. Indicators | Responsibility | | | |
| | 2012 | | | 2013 | | | | 2014 | | | 2015 and beyond | | | | | | | | |
| Commission cost and benefit analysis for the integration | x | x | x | | | | | | x | x | | | | | | | \$20,000 | | MOH |
| Commission Quality of care dimensions study | x | x | x | | | | | | | | | | | | | | \$20,000 | | |
| Collaborate with research institutions (e.g. BHP) for relevant clinical trials in support of the integration | x | x | x | x | x | x | X | x | x | x | x | x | x | x | x | x | \$ () | | |
| Identify operations research needs for the integration | x | x | x | | | | | | | | | | | | | | - | | |
| Commission operations research and evaluation of pilot phase | | | | | | | X | x | x | x | | | | | | | \$ 40,000 | | |

Table 11: Community mobilization implementation plan

| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | | | | |
|----------------------------------|---|---|--|------|--|--|------|--|---|-----------------|--|--|-----------------------------|--|----------------|-----|--|--|
| COMMUNITY MOBILIZATION | Increase in number of men seeking SRH services Increase in number of people seeking services (weakest links). Increase in youth seeking SRHR services | | | | | | | | | | | | Facility records | The training of the cadre will be timed ahead of the sensitization of communities, homes, church members, Kgotla meetings. | | | | |
| Activities | PILOT PHASE 2012-2014 | | | | | | | | | | | | Est. Cost (\$) | Mon. Indicators | Responsibility | | | |
| | 2012 | | | 2013 | | | 2014 | | | 2015 and beyond | | | | | | | | |
| Training of HEAs | x | x | | | | | | | x | x | | | | | | (?) | | DHMTs - the district focal persons will coordinate the process |
| Training of Lay Counselors | x | x | | | | | | | x | x | | | | | | (?) | | |
| Training of Peer mothers | x | x | | | | | | | x | x | | | | | | (?) | | |
| Training of Priests and teachers | x | x | | | | | | | x | x | | | | | | (?) | | |

Table 12: Materials development implementation plan

| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | | | | |
|--|--|---|---|------|--|--|------|--|--|-----------------|--|--|-----------------------------|-----------------|----------------|--|--|--|
| Materials development* | Usage of the materials by service providers Posted materials in facilities Usage of materials by the non-health institutions | | | | | | | | | | | | Copies of the materials | | | | | |
| Activities | PILOT PHASE 2012-2014 | | | | | | | | | | | | Est. Cost (\$) | Mon. Indicators | Responsibility | | | |
| | 2012 | | | 2013 | | | 2014 | | | 2015 and beyond | | | | | | | | |
| Development and printing of Integration guidelines | x | x | x | | | | | | | | | | | | | | | |
| Linkages material for health workers and users | x | x | x | | | | | | | | | | | | | | | |
| Linkages material for the non-health institutions | x | x | x | | | | | | | | | | | | | | | |
| Media packs | x | x | x | | | | | | | | | | | | | | | |

*NB: Collaboration with CDC for this component is envisaged

Table 13: Service provision

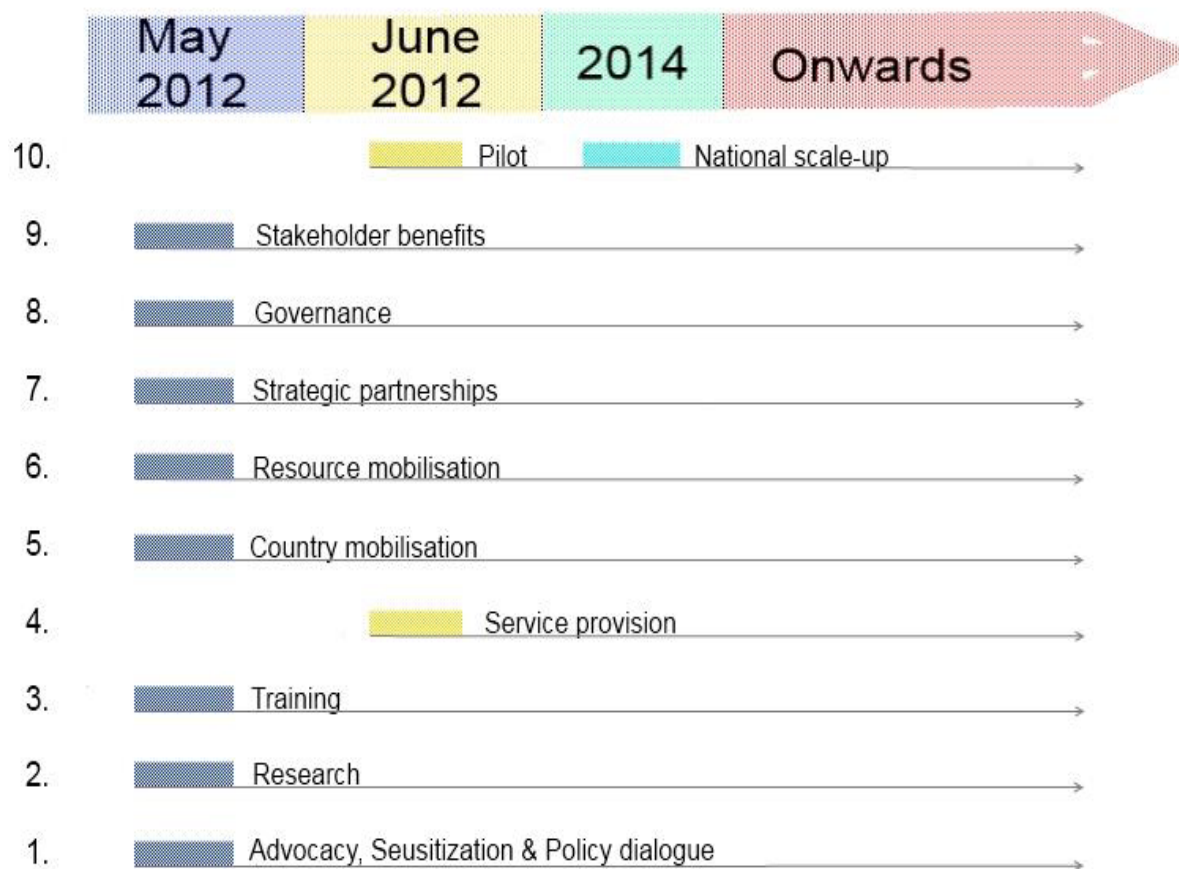
| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | |
|---|--|--|--|------|--|--|------|---|--|-----------------|--|--|-----------------------------|-----------------|----------------|
| SERVICE PROVISION | Costed needs for the integration at from each of the 3 pilot districts | | | | | | | | | | | | | | |
| Activity | Pilot phase 2012-2014 | | | | | | | | | | | | Est. Cost (\$) | Mon. Indicators | Responsibility |
| Needs assessment from the pilot districts and national up-scaling | 2012 | | | 2013 | | | 2014 | | | 2015 and beyond | | | | | |
| (a) Human resource needs | x | | | | | | | | | | | | | | |
| (b) Training needs | x | | | | | | | | | | | | | | |
| (c) equipment | x | | | | | | | | | | | | | | |
| (d) supplies | x | | | | | | | | | | | | | | |
| (e) infrastructure | x | | | | | | | | | | | | | | |
| Consultant to assist with the process in May for the pilot and in 1 st quarter of 2014 for the national scale-up | x | | | | | | | x | | | | | | | \$20,000 |

Table 14: Training

| Objectives | Objective Verifiable Indicators (OVI) | | | | | | | | | | | | | Means of Verification (MOV) | Assumptions | | |
|--|--|----|---|------|---|---|------|---|---|-----------------|--|--|--|---|---|----------------|--|
| TRAINING | Teaching of relevant integration topics to trainees at health and Teachers Training Colleges | | | | | | | | | | | | | Revised curricula for I.H.S and UB school of Nursing Trained Staff at I.H.S and UB school of Nursing | The timing of the curriculum review and training will be adhered to. The costs envisaged will be mainly consultancies. Staff will be available to counterpart the consultants | | |
| Activities | PILOT PHASE 2012-2014 | | | | | | | | | | | | | Est. Cost (\$) | Mon. Indicators | Responsibility | |
| | 2012 | | | 2013 | | | 2014 | | | 2015 and beyond | | | | | | | |
| Curriculum review for pre-service teachers | x | x | | | | | | | | | | | | | | | |
| In-service training for health workers | x | x | x | x | X | | | | | | | | | | | | |
| In-service training for teachers | x | x | x | x | | | | | | | | | | | | | |
| Training I.H.S staff | | x | x | x | X | x | x | | | | | | | | | | |
| Training UB Nursing staff | | x | x | x | X | x | x | | | | | | | | | | |
| Curriculum review UB school of Nursing | x | x | x | | | | | | | | | | | | | | |
| Curriculum review for pre-service health trainees at I.H.S | x | x | x | | | | | | | | | | | | | | |
| Activity | Time Frame | | | | | | | | | | | | | Est. Cost (\$) | Mon. Indicators | Responsibility | |
| | 2012 | | | 2013 | | | 2014 | | | 2015 and beyond | | | | | | | |
| Review of SRH/ HIV/AIDS content of wellness programmes | x | x | x | | | | | | | | | | | | | | \$20,000 |
| CSO training | x | xx | x | | | | | x | x | | | | | | | | \$15,000 (training will be done jointly) |
| Training of quasi govt. health institutions | x | x | x | | | | | x | x | | | | | | | | |
| Training of media | x | x | x | | | | | x | x | | | | | | | | |
| Sensitization of DMSACs | | | | | | | | | | | | | | | | | |

Diagram 4: Implementation phases and plan

8. IMPLEMENTATION PHASE GATES



This diagram depicts the plan for implementing the pilot and national scale-up. All activities directed by the strategies are expected to be effective in May 2012. Service provision will coincide with the beginning of the pilot phase. The implementation plan is based on this phase gate diagram.

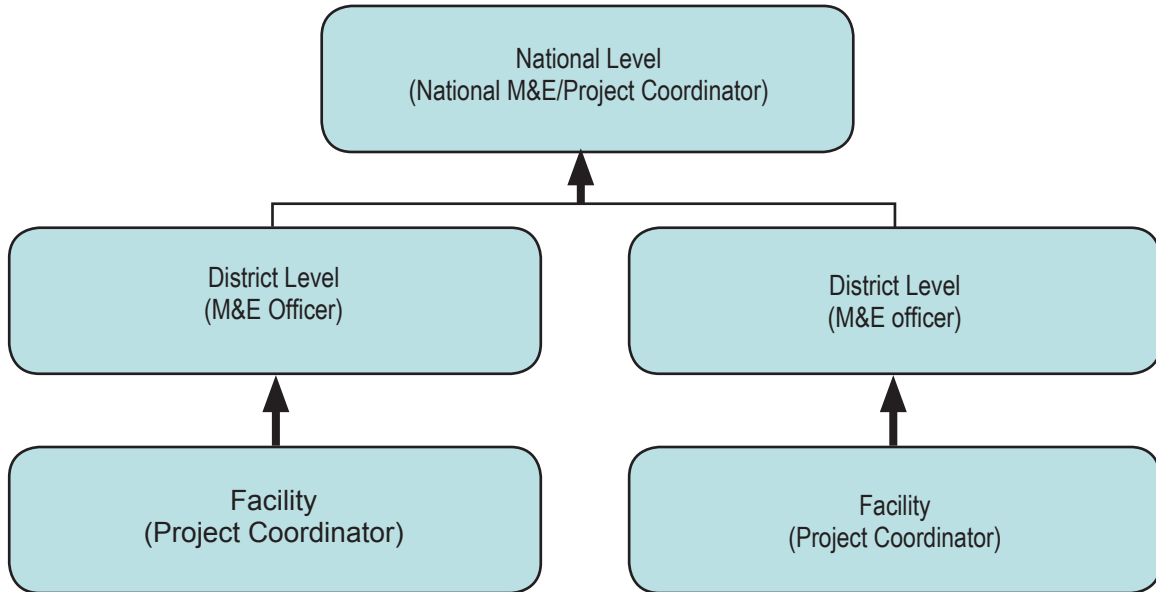
Monitoring and Evaluation

The SRHR/HIV Linkages strategy identifies monitoring, evaluation and research as a critical pillar to guide its successful implementation. This section is intended to provide a broad framework for the MOH and its stakeholders to operate under with regard to the important aspect of monitoring and evaluation. This is particularly true during this pilot phase when it is immensely critical to draw pertinent lessons to guide future implementation. Invariably decision makers will rely on quality information to determine the specific aspects of linkages that can be successfully scaled up in Botswana.

Consequently, the implementation of the SRHR/HIV Linkages strategy will be systematically tracked through the established MOH Monitoring and Evaluation (M&E) system. In fact this approach draws credence from the very fact that most of the activities to be implemented under this strategy are already being tracked through their respective program areas. Efforts will be made to ensure that the M&E systems in place will espouse the ideals of integration and seek to minimize the risks of fragmentation and other duplicative processes. This will mirror the on-going efforts at the MOH to have one M&E system

Programmatic indicators from the relevant implementation areas will be harmonized and collected through the routine health information system, recognizing the important role of the district health systems as planning and implementation structures within the health system in Botswana. The availability of complete health information in a timely manner is critical for policy, planning and for operations based on informed and sound decisions. Therefore for data to be efficiently used, it is important that there are clear guidelines with regard to data collection, collation, analysis and interpretation. The end result should be a viable information system that can effectively monitor and evaluate health service delivery.

Data Flow Figure



- Collection

Relevant programmatic data will be collected from the facilities using the regular MOH data collection forms. Where applicable the data collection forms will be modified to capture specific indicators relevant to the linkage and integration process.

Caution will be exercised not to burden the existing M&E system, cognizant of the fact that in the event of scaling up to the national level, the system should be sustainable. Given that understanding, data on routine project activities e.g. advocacy sessions and meetings and other administrative functions will be collected by the project coordinator through an alternative system.

- Collation

The data cleaning and collation processes will be done at both the facility and the DHMT level. At the facility level, the project coordinators shall compile the relevant data collection forms on a specified schedule and send them to the district level. At the DHMT level, the M&E officer shall be responsible for data entry. The District Health Information System (DHIS) shall be instrumental in the implementation of this function at the district level. Built in validation checks will ensure the quality of the data at this level. Upon entry at this level, the data shall be available online at the national level for further interrogation.

- Analysis

Data analysis shall be done both at the district and national levels using the DHIS. The District M&E officer has the responsibility of generating routine programmatic reports for his/her district. The programmatic reporting for the SRH/HIV linkages pilot project shall take the same form, whereby the M&E officer shall be tasked with responsibility of generating routine statistics on a specified time. Care shall be exercised not to burden the system. Similarly at the national level, the analysis shall take the same form.

- Reporting

Reports on different programmatic statistics will be generated routinely and reported alongside other MOH indicators as per the established protocols. The project specific reporting will be the responsibility of the National Project Coordinator, who will also be tasked with report dissemination to different stakeholders.

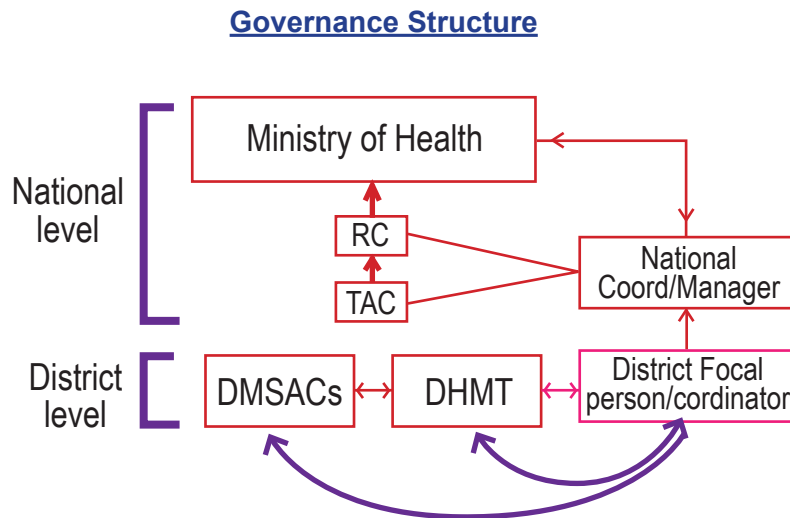
Evaluation:

After the pilot phase, evaluation findings will inform the future decisions in terms of scale up and overall implementation of the SRH/HIV linkages. In order to have a firm basis for a rigorous evaluation design, a baseline study will be undertaken to establish the prevailing circumstances in the SRHR and HIV&AIDS landscape. After a period of implementation an end of project evaluation will also be done to deduce any changes that could have happened as a result of the project. The evaluations will focus on both outcomes at the population level as well as processes that will be informative to the implementation dynamics.

9. GOVERNANCE STRUCTURE AND ROLE DELINEATION

The governance arrangements and their corresponding roles are clarified below. These are responsibilities for the Ministry of Health, the Reference Committee (RC), the Technical Advisory Committee (TAC), the District Health Medical Team (DHMT), the District Multi-Sectoral AIDS Committees (DMSACs), the National Coordinator and District Focal Persons.

Diagram 5: Governance structure



9.1 The envisaged role of the Ministry of Health

The envisaged role will include: -

- the overall responsibility of developing and managing the integration at all levels during the pilot and subsequent phases
- Coordination of the integration at all levels of policy and programme.
- mobilizing and sustaining resources
- advocating for the inclusion of all relevant stakeholders
- Reporting to donors on the implementation of the integration and the sustainability of the entire project.
- Evaluation of the project after the pilot and advising on the direction for the national roll-out

9.2 The role of the Reference Committee

The specific functions of the National SRH/HIV Linkage Reference Committee are to:-

- Mobilize resources to develop and implement an integrated strategy for effective linkages between HIV and SRH.
- Oversee the development and implementation of the SRH/HIV linkage strategy.
- Ensure coordinated budgeting, planning, implementation, monitoring and evaluation of prioritized SRHR and HIV & AIDS integration and interventions.
- Contribute to the development and review of policies, guidelines and strategies on SRHR and HIV interventions.
- Coordinate the interagency support to harmonize implementation of SRH/HIV Linkages in Botswana.
- Oversee the monitoring progress of the implementation of the SRH/HIV Linkages like the EU project closely.
- Advocate for human resources development in SRHR and HIV & AIDS to improve linkages at all levels.
- Represent Botswana in international SRH/HIV Linkage platforms.

- Approves SRH and HIV & AIDS integration and linkage plans and reports.
- Advocate for human resources development in SRHR and HIV & AIDS improve linkages at all levels.
- Support development of framework and plan for M&E and visibility.

9.3 The role of the Technical Advisory Committee (TAC)

Specific functions of the National SRH/HIV & AIDS Linkages Technical Advisory Committee (TAC) are to:-

- Develop of strategy for SRHR and HIV & AIDS linkages.
- Provide technical assistance in planning, budgeting and implementation of bi-directional SRHR/HIV linkages, including eMTCT.
- Support the development of institutional capacity for delivering quality SRHR and HIV& AIDS services.
- Support development of an SRHR and HIV& AIDS linkages annual work plan.
- Monitor implementation and submit annual reports to the National SRHR and HIV& AIDS linkages Reference Committee for approval.
- Document good practices, lessons learned and success stories of SRHR/HIV & AIDS linkages.
- Identify and mobilize stakeholders to participate in the implementation of the SRHR and HIV& AIDS integration and linkages.
- Mobilize local and international institutions, private sector and civil society for technical and financial support.
- Advocate for human resources development in SRHR and HIV& AIDS to improve linkages at all levels.
- Support development of framework and plan for M&E and visibility.

9.4 The envisaged role of the National coordinator

As presented above, under the supervision of a manager from the Public health Department, the national Coordinator will among others ensure the following: -

- Develop a composite monitoring plan from the implementation plans (pilot and national)
- Monitor process, output and outcome indicators of success
- The implementation of the approved recommendations
- Smooth take off of the pilot phase and its evaluation
- Keep track of the implementation plan and feedback to the TAC and RC
- Maintain updated inventory of health and non-health stakeholders
- Liaise between the ministry of health and health and the non-health institutions and ensure their needs are provided
- Keep track of the benefits, needs and expectations of the stakeholders and ensure they are realized.
- Keep close contacts with district focal persons in the districts and feedback progress of implementation and challenges to the ministry and back to the Focal persons with feedback and provide occasional support when required. Arrange monitoring visits for RC and TAC
- Write monthly reports on the integration for the ministry of health TAC and the RC

9.5 Specific support to the non-health institutions (CSOs, NGOs, Government ministries and departments, private sector companies and institutions and the media)

The national coordinator under the supervision of the Ministry of Health will ensure the participation of the non-health umbrella institutions and other non-health institutions at the national level such as BONELA, BOCONGO, ministries, private sector; BOCCIM by doing the following: -

- Maintain an updated inventory
- Provide forum to learn about their roles
- Strategic engagement
- Advocate and support resource mobilization
- Support capacity building
- Engage them at appropriate levels (Coalition at national and umbrella at the district levels)
- Market the integration for their buy-in
- Give them tools for measuring progress and impact
- Monitor
- Evaluate and pick lessons and share with TAC and RC

9.6 The envisaged role of district focal persons

Under the supervision and of the DHMT the district Focal will among others: -

- Be the focal person in the district for the integration project
- Monitor process, output and outcome indicators of success
- Provide support in activities planned for the pilot phase
- Organize with the help of the DHMT sensitization about the integration in the facilities and at the DMSACs in conjunction with the DAC Officer
- Maintain an updated inventory of the integration stakeholders particularly the non-health institutions and ensure their participation at DMSAC meetings; to plan, implement, evaluate and report
- Ensure stakeholders have their needs provided for the integration
- Liaise between the district facilities and the DHMTs
- See to the smooth running of the pilot phase and provide feedback systematically to the DHMTs
- Link up with the National coordinator and provide feedback on progress regularly. Weekly updates, monthly and quarterly reports are recommended

9.7 The envisaged role of DHMTs

Given the mandate of DHMTs, it is proposed that they have complete oversight for the integration. During the pilot phase the following are expected from the 3 DHMTs of the pilot districts: -

- Identify appropriate model/s for each facility for integration
- Agree on its architecture based on the resources available and gaps that can be filled resourcefully (avoiding capital intensive options as much as possible)
- Policy and guidelines on linkages and integration will be developed and piloted
- Conduct needs assessment to establish resource needs including HR and basic skills required by service providers including pharmacists, H. Education Assistants, and lab Technicians.

- Implement the integration taking into account the findings from the rapid assessment particularly the weakest links (PAC, GBV, SRHR linkages)
- Establish indicators of measurement
- Monitor and report appropriately
- Lessons learned will be used for up scaling in the entire country

9.8 The envisaged role of DMSACs

The DMSACs in conjunction with the DACs will undertake the following to ensure the full participation of the non-health stakeholders in district level planning, programme development, management monitoring, evaluation and reporting.

- Maintain updated inventory of the stakeholders
- Market the linkages and their benefits
- Advocate for their buy-in
- Provide integration package, guidelines and standards
- Build their capacity
- Monitor standards
- Convene monitoring visits
- Capture their contribution through adherence to completing and submitting returns on integrated M&E tools

10. SUSTAINABILITY

Key factors for sustainability include: -

- meeting the needs and expectations of stakeholders
- assured funding
- assured realization of stakeholders' benefits
- continuous addition of value to all stakeholders.

Capacity building generally was considered as a means to sustain the integration. Since capacity building was considered an opportunity for professional growth, and a means for boosting service providers' confidence and for assuring client trust its realization is likely to sustain the integration endeavour. The health personnel in question here are midwives, family nurse practitioners, Health Education Assistants, Pharmacists at IDCCs and Lay Counselors.

Sustainability factors suggested by the private health institutions and the non-health private institutions include improved collaboration between themselves and the ministry of health, e.g. participation in Ministry of Health's organized training, provision of materials and drugs.

Resource mobilization and funds that are flexible for use by both SRHR and HIV&AIDS was also considered critical for sustainability.

11. RECOMMENDATIONS

The recommendations below form the basis for the strategic objectives, actions and the implementation plan.

11.1 Accelerated plan for training of health providers

The numbers and kind of training required for the integration at each facility level will have to be established through needs assessment study recommended to be done by the DHMTs.

11.2 DHMTs or MOH to consider posting doctors and midwives at clinics with maternity wings or health posts.

Doctors and midwives must be attached to Clinics with maternity or health posts.

11.3 Community mobilizers should be equipped with the necessary skills and knowledge to educate and inform the general public in communities about the essence of the integration and its availability

11.4 From the proposed models (mall, supermarket and kiosk) DHMTs should decide on an appropriate facility specific models for integrating and create the necessary structures and their respective architecture and needs for operationalizing and maintaining the model. This would enhance ownership, accountability, responsibility and sustainability of the integration.

11.5 There should be greater collaboration between the Ministry of Health and the private health and non-health institutions to achieve the following:-

- Use of harmonized tools to capture health outcomes/contribution from the private sector to avoid the loss of pertinent information from private health and entire non-health institutions
- Achievement of uniform standards for quality service delivery
- Inventory of stakeholders in that sector for mutual exchange/transfer of expertise and technology
- Reaching most at risk population
- Required demand and ensuring that HIV services are acceptable and of good quality
- Preparing communities for treatment and adherence to medication
- Other forms of care and support

This collaboration entails participation in training, access to information regarding the integration and usage of reporting tools and their adherence to integration standards.

11.6 Evidence based programming will be done through target, population and issue specific empirical (including clinical trials, research, operations research, social and anthropological studies, cost and benefit analysis) research to bridge the current research gaps in SRH and HIV&AIDS research agendas.

11.7 Intra component linkages should be established as the starting point for the integration

Although bi-directional linkages were identified in the country at the facility levels, weak intra SRHR linkages were identified within SRH components during the Rapid Assessment. The weaknesses should be strengthened as a prerequisite for effective integration. Similarly weaknesses in intra HIV&AIDS component linkages should be strengthened although this was minimal.

11.8 Bi-directional HIV&AIDS and SRHR component linkages should be strengthened in order to address weaknesses in HIV&AIDS and SRHR inter component linkages

11.9 Efficient data capture and information management

The rolling out of PIMS II should be expedited

11.10 An M&E plan for the entire project

This should take cognizance of the implementation plan and other plans particularly the Log Frame for the project.

11.11 Collaboration with private hospitals and clinics

Greater collaboration between the MOH and the private practitioners Associations will ensure their support and participation.

11.12 The SRHR Policy Guidelines and Service Standards and HIV&AIDS Strategic Frameworks, and other health strategies should be reviewed in line with the linkages and their integration

The gaps in these documents should be filled progressively.

11.13 Service providers should take into account special needs of people with disabilities.

11.14 Service providers should take into account the needs of emerging populations such as MSMs.

12. CONCLUSION

Given that government's SRH policy standards and guidelines are clear on achieving comprehensive service for the population, SRHR and HIV&AIDS integration process will benefit from a positive policy environment. The two departments that house SRH and HIV&AIDS at the Ministry of Health are now merged which provides additional strategic strength to the integration process.

The critical success factors of the SRHR and HIV&AIDS integration strategy will include; (1) a service provider with an integrated mindset and skills with commitment and dedication to deliver integrated SRH and HIV services to all users, (2) a non-health institution with an understanding and knowledge to equip their membership with relevant information and skills to demand SRH and HIV service at health delivery facilities, (3) adherence of users to their rights and responsibilities (user tolerance and cooperation), (4) supportive environment (policy, legal, resources, supervision and management) and (5) strategic partnerships.

13. ANNEXES

I. METHODOLOGY

Qualitative research methodologies were used to collect information for analyses to produce the strategy and implementation plan. The methodologies included desk reviews of policy documents, international and regional legal conventions and agendas, curricula of training institutions, health programmes and strategies and reports. In-depth interviews were also held with stakeholders.

Facilities in the 3 Pilot sites were visited. They included Letlhakeng sub-district (Sesung Clinic without maternity, Letlhakeng Clinic with maternity, Khudumelapye Clinic without maternity), Mahalapye (DHMT, District hospital with Youth Friendly Clinic, DHMT Sefhare primary hospital, Shoshong Clinic with maternity, Otse health post and Kgatleng (Mochudi Clinic 1, DHMT, BOFWA) to interview users and providers of service to capture lessons. Some exit interviews and service provider observations were also conducted which provided information about the package of services they had received and to find out to what extent those services had been comprehensively delivered.

A simulation session was done with the intent of estimating the time health providers would need to spend with users to provide the integrated and comprehensive care. The mix of methods satisfied the requirement for triangulation in research methodology.

Selection of pilot

Pilot districts were selected based on their proximity to Gaborone for close monitoring purposes, availability of almost all levels of health facilities; district hospital, primary hospital, clinics (with and without maternity), health posts, districts with the most health facilities, private health facilities and non-health institutions.

Tools and techniques

Tools and techniques included expert judgments, communication skills, brainstorming, interviews, focus group discussion, best practices, information gathering and meetings.

Scope

- Identifying the strategic linkages between SRHR and HIV&AIDS
- Identifying points and levels for their integration
- Proposing models for the integration at these points and levels
- Developing a responsive strategy for piloting the integration as a basis for rolling out nationally
- Developing an implementation plan
- Proposing a governance structure and making
- Recommendations for the integration

Method of Analysis

Thematic analysis procedure was used for analyzing the data under the following broad headings used in collecting the data.

II. SITUATIONAL ANALYSIS

(a) External/global goals and conventions

Global and national SRHR and HIV/AIDS goals and conventions, policy guidelines and standards, development plans and guiding principles for SRHR and HIV/AIDS strategy

Of the 27 relevant conventions (see annexes) identified where Botswana is signatory 25 relate to HIV and AIDS while 8 of them are exclusive to SRH. It can be said that gaps in integration of health components in conventions exist particularly since the inception of the pandemic in 1981. The current global call on governments to speed up efforts at integration for improved health outcomes will require additional commitments based on a review of the relevant conventions and preparing addendums to ensure comprehensive and systematic approaches that are feasible and leverage on available resources including maximizing and optimizing those resources to determine the approaches and strategies. Policy guidelines for SRH included HIV as an STI but lacked the comprehensiveness that is required. A review opportunity will have to consider a comprehensive approach where lessons learned could be an input. HIV&AIDS policies and their Frameworks however had very scanty mention of SRH. The connections are absent. A more thorough review of this will be necessary.

(b) Programme components of SRHR and HIV/AIDS, their linkages and integration

The programme components of SRH (see Table 1 and 2) as stated in the MOH's Policies and Standards document for SRH are comprehensive and cover the allowable SRH services for the entire population from birth to old age. However, these services are not known uniformly by health workers. Generally, health workers considered ANC, PNC and FP as the main components of SRH.

According to the 2008 Rapid Assessment of SRH and HIV&AIDS linkages in Botswana, several HIV services including HIV Testing and Counseling, prophylaxis and treatment for PLWHA, comprehensive primary and secondary prevention and even services for sex workers are linked with the most commonly available SRH services, i.e. FP, STI and MCH. Similarly, FP, STI and MCH are linked with several HIV services but GBV and PAC services are least likely to be linked. GBV and PAC services were shown to be least available and least likely to be linked when they are jointly available. The report concluded that services can be linked directly by providers only if both (SRH and HIV) are available in the facility.

In addition it was reported that the largest proportion of female clients received MCH, FP and condom services whereas the largest proportion of male clients received HIV monitoring and treatment and condom services. However, the highest joint availability is among the most widely available SRH services. Most providers at all types of facilities reported that these services were linked by the same provider on the same day. They also stated that almost no service sites reported linking SRH services within HIV counseling and testing. Providers reported that fewer SRH services were linked to the delivery of HIV services as opposed to HIV services linked to the delivery of SRH services. In total only about 30% of clients at the facilities visited reported that they received both SRH and HIV services²⁶.

From the report, it is clear that the most common SRH services provided are FP, STI and MCH. Considering that the Ministry of Health's policy guidelines and service standards call for comprehensive service delivery, there will be the need to bridge the gaps that were identified in the rapid assessment in order to optimize integrated service delivery.

(c) Models at the Health facilities

Three models were found at the public facility levels. These are the 'Mall', 'Supermarket' and 'Kiosk' models.

The 'Mall' model

As defined in the definition section of the report, the Mall model is exemplified by SRH and HIV and AIDS services provided in primary and district hospitals. All specialized services are available in these facilities but are more compartmentalized compared to other facilities as such as the health post and clinics. The infrastructure of these facilities favours this kind of arrangement. However, given that providers are trained to offer comprehensive service, integration can occur but the challenge will be the users walking distances within the hospital and joining different queues in order to access the services. Service providers are trained to provide comprehensive services but very few of the prescribed services such as FP, MCH and STI services are linked and provided at the same location as reported by the Rapid Assessment report.

In addition to these hospitals are the 3 Referral hospitals in Gaborone, Francistown and Lobatse. These offer specialized services. Cases requiring specialized attention in SRH are referred from district and primary hospitals, clinics and health posts to these 3 hospitals. Examples of such referral cases are obstetric emergencies during pregnancy, labour and delivery, and during puerperium.²⁷ Lobatse Referral hospital is a specialized hospital for psychiatry patients whose SRHR needs are also very critical (See SRH rights section on SRHR needs of people with disabilities).

Given the structure and role of these hospitals therefore, major changes structurally are not envisaged for them to operate integrated services. These facilities will continue to provide SRH and HIV and AIDS services from their designated locations. However, given the comprehensiveness of the integration and the objective of providing better client-focused care with least disruption, service providers will be oriented and trained to deliver integrated services at these locations within the hospital.

This is because all referral hospitals are completely equipped for all the services but the locations for the services are spread and as such the services are compartmentalized. The change expected in the era of integration is that service providers will no longer use their 'discretion' but will follow prescribed integration guidelines to deliver proactive, preventive and curative service to all SRHR and HIV clients. The intention of the integration is for all clients to obtain all the integrated services whether they were referred or are first time clients in any of the facilities. SRH and HIV locations within the hospital are required to provide complete integrated service to all clients (ref. linkages and integration package).

²⁶ Rapid Assessment of SRH and HIV & AIDS 2008

²⁷ SRH Policy Guidelines and Policy Service

The 'supermarket' model

This is the model found in some clinics. Not all services are provided but the available linked services are provided in one location. Service providers provide the services they are trained for and refer the rest to hospitals. One pharmacy visited in a clinic had medicines for both SRH and HIV. Integrated pharmacy is therefore one option that can facilitate integration service delivery. It was observed that medical doctors and midwives will have to be deployed to facilities where these personnel are not available on specified days.

The 'kiosk' model

The kiosk model was found at health posts mainly. This is where SRH and HIV and AIDS services are limited due by space and personnel. Additional space in the form of porter cabins will have to be procured for the pilot sites. Human resource needs and additional space requirements will have to be determined by the DHMTs. Similar requirements will have to be agreed upon for mobile stops.

(d) Users and service provision

(i) Users

Users would prefer services provided to them during one visit to the facility, avoiding repeated visits.²⁸ They would like to receive comprehensive care and avoid long queues and be seated comfortably not in harsh (hot or cold) conditions and on hard benches. They would also like not to wait for long hours and be treated with dignity and respect.

(ii) Providers (public)

From the provider's point of view, the need to clarify the full spectrum of SRH components was of concern and in this regard they asked for it to be the starting point. All service providers interviewed wanted knowledge and skills pertaining to the entire spectrum of SRHR. It was unanimously agreed that gaps in skills and knowledge concerning SRH and HIV&AIDS should be provided as a matter of urgency. It became clear that the most needed health provider for the integration was the midwife. Midwives however happen to be in short supply and therefore the need to consider alternative ways of maximizing the current numbers to meet the demand at the health facilities is of prime concern. The human resource needs for the integration will be included in the entire needs assessment for integration that DHMT's are required to undertake. In addition to leveraging this resource, the possibility of a long-term plan for the training of midwives can be explored. The I.H.S and the UB School of Nursing are two institutions consulted for this purpose.

(iii) Providers (private)

There were concerns about the need for uniform knowledge of SRH among executives of stakeholders, service providers and clients. Additional concerns related to adherence to quality service delivery. Given that integration may call for clients spending more time with service providers, there was that concern that quality may be compromised. Talking to clients however, they gave the assurance that provided the new process and the benefits to be derived is explained, they would be prepared to wait for their turn to be provided with the comprehensive service. This means therefore that sensitization of the integration process will have to include clients as targets.

To them, ownership was a key function to the success of the integration. They would like to see integration as government's priority backed by commitments. Some of the key indicators of this commitment should include orientation of service providers across board to be abreast with the current policies, practices and technologies on the linkages and their integration. They called for more collaboration in terms of participation in training, provision of supplies and use of harmonized tools. They called for improvement in the legal environment with regard to emergency contraception and abortion. Some of them raised the issue of the illegality of safe abortions as a constraint for young people particularly in dealing with unwanted pregnancies. They also called for recognition of the few NGOs providing services. Training of their cadre constituted the most pressing need. They called for prompt action in disseminating guidelines on the linkages and the integration process.

The knowledge base for the integration is critical and the strategy takes cognizance of it. In-service and pre-service (long term) has been taken care of in the strategy development. However, at the facility level, coaching and mentoring will be required to complement in service training and to be able to produce efficient service delivery on site. This will form a part of DHMTs responsibilities. DHMT will complement the national endeavors in this regard.

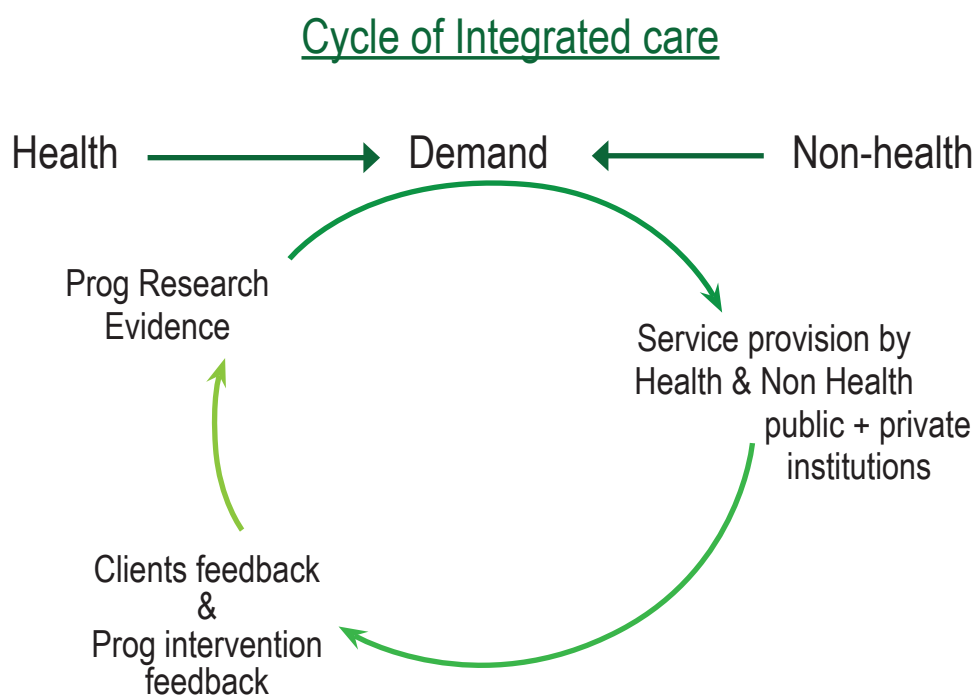
The concerns of the private sector, with regard to the legal and policy environment have also been taken care of by the strategic objectives. The involvement of the private sector at the national and district level and the need for government recognition has been addressed by recommending greater involvement and participation at levels of coordination and management such as DHMT and DMSAC at the district levels, programme Reference Committee, Technical Advisory Committee levels where there will be opportunity for them to share information and advocate for the provision of their needs for the integration.

²⁸ *ibid*

(e) Cycle of integrated care

The Botswana SRHR linkages and integrated care is seen as shown below. It shows a cycle of care that hinges on collaborative demand from the health and non-health (CSOs, NGOs, government ministries and departments, the private sector companies and institutions and the media) sectors. Service is then provided by both private and the public institutions. Clients and programme interventions feedback may prompt research for evidence and results for improved service provision.

Diagram 1: Cycle of integrated care



(f) Training, research and curriculum development

Two academic and one research institution were consulted, namely The Institute of Health Sciences (I.H.S), the University of Botswana (UB) School of Nursing and Botswana Harvard Partnership (training and research). At the I.H.S and UB School of nursing, gaps in their curricula were identified. It was discovered that I.H.S and UB School of Nursing were in the process of conducting curricula reviews. These present opportunities for MOH to advocate for the inclusion of the approved SRH and HIV&AIDS linkages and corresponding packages for the integration. As mentioned earlier, a detailed proposal was received from the I.H.S which demonstrates commitment to the course of integration. Considering that I.H.S is a major trainer of health personnel for the country, their engagement for this purpose will assure qualitative training of the critical cadre for the integration at the facility levels (630 health facilities in 28 districts)²⁹.

The curriculum division of the MOESD will be reviewing their curricula, teacher's guides and students work books for the necessary addendums based on the requirements from the MOH on the linkages. Opportunities also exist in integrating the linkage package and integration requirements in the training colleges' pre-service and in-service training curricula.

MOH outsources some of the HIV & AIDS interventions (ARV, PMTCT-TAP training and clinicals) to partner organizations such as BHP. MOH's collaboration with BHP research will ensure that relevant research (clinical trials) will be conducted to improve SRHR and HIV&AIDS linkages as well as improve quality of comprehensive care to the community.

(g) Stakeholders

The consultations established that the integration is of great interest to diverse stakeholders. The interest ranged from those whose mandates conform to the integration subjects to those who are in the business of developing capacities, providing technical assistance or funding. Given that the strength of the strategy hinges on the full engagement of both health and non-health institutions in the private and public sector, stakeholder engagement becomes critical.

Their needs and expectations will have to be known and managed throughout the life span of the project and beyond. Stakeholders are at the national and district levels.

²⁹ Health district by type and district, MOH 2010

(h) Stakeholders needs and expectations

The different stakeholders expressed their expectations and needs and the benefits they expect to derive from their participation as shown in the two tables below.

Table 1: Expectations and needs by category of stakeholders

| Category of stakeholders | Advocacy | Commitment from stakeholders | Training and skills | Research | Financial resources | Regular supplies | Quality of care |
|----------------------------------|----------|------------------------------|---------------------|----------|---------------------|------------------|-----------------|
| Key stakeholder (MOH) | x | x | | | x | x | x |
| Development cooperation agencies | x | x | | | | x | x |
| Funders | x | x | | | x | x | x |
| CSOs | x | x | x | x | x | x | x |
| NGOs | x | x | x | x | x | x | x |
| Service providers | | x | x | | x | x | x |
| clients | x | x | | | | x | x |
| DHMT | x | x | x | x | x | x | x |
| Training institutions | x | x | x | x | x | x | x |

Regular supplies, quality of care and commitment from stakeholders were the most prominent among the needs and expectations implying that stakeholders will be expecting a quality integrated system where supplies do not run out. Commitment from stakeholders at all levels was also considered a criterion for success. Service providers' needs centered on issues that will ensure efficient delivery. This is a welcome observation. One would have expected issues of incentives in addition but this was not mentioned by service providers.

Table 2: Benefits expectations of stakeholders

| Category of stakeholders | Skills | Career growth | Value | Quality of care | Confidence and morale | Professionalism |
|----------------------------------|--------|---------------|-------|-----------------|-----------------------|-----------------|
| Key stakeholder (MOH) | | | x | x | | |
| Development cooperation agencies | | | x | x | | |
| Funders | | | x | x | | |
| CSOs | x | x | x | x | x | x |
| NGOs | x | x | x | x | x | x |
| Service providers | x | x | x | x | x | x |
| clients | | | | x | | |
| DHMT | x | x | x | x | x | x |
| Training institutions | x | x | x | x | x | x |

It is worth noting that service providers recognized the integration as an opportunity for growth in order to provide quality of care to clients. Clients on the other hand, expressed benefits they expect to derive as quality of care from service providers. Training institutions saw the integration as an added opportunity to acquire new skills and achieve professionalism.

It was apparent that one of the keys to the success of the integration will be the assurance of realizing the expectations and the benefits of stakeholders as presented in the tables. There will be the need therefore to ensure their delivery. These also will be done by the Focal persons and national coordinator with assistance from the TAC and RC of the project at the national level and the DHMT at the district levels.

(i) Non-health institutions (development partners, CSOs, NGOs, Government ministries and departments, the private sector companies and institutions and the media)

The need to combine prevention and curative strategies at all levels for the integration became apparent. These are provided by both health and non-health institutions from both private and the public sector. The need for complimentary strategies between health and non-health institutions from public and private sectors will therefore enhance division of labour and utilize comparative advantages of each sector. The non-health institutions **(development partners, CSOs, NGOs, government ministries and departments, the private sector companies and institutions and the media)** will play the following roles but not limited to: -

1. Building capacity of their membership and support groups to reach the difficult to reach (outlying areas e.g. settlements)
2. Addressing risky behaviors; MSMs, IDUs, IGS, MCPs,
3. Community mobilization to create demand for SRH gaps including SMC, SRHR needs of young and adult men e.g. infertility, reproductive tract cancers, support to their spouses,
4. Proactive and responsive prevention (positive and negative HIV population)
5. Create demand for SRHR and HIV&AIDS services at various levels including: -
 - Workplace
 - Support groups of PLWAs
 - Community level such as at Kgotla meetings and through various community mobilization strategies
 - Schools, youth clubs, Associations
 - Churches
6. Advocacy to influence the implementation of ratified conventions and agendas
7. Community awareness and education about laws and rights related to HIV&AIDS and SRHR
8. Advocating and promoting the provision of livelihoods for deprived and vulnerable groups within communities.

Development partners in health have major stakes in the SRHR integration. Notably among these are UNFPA, EU, WHO, UNICEF, CDC and BHP. Strategic partnerships envisaged are in the areas of research, training and materials development and funding. Representatives from these and other partner agencies serve on the Reference and Technical Advisory Committees of the project.

(j) Lessons from success stories on SRHR and HIV&AIDS integration

Tanzania

Tanzania is one of the many countries integrating SRHR and HIV&AIDS services. The following success stories are related to the integration of Youth Friendly Services (YFS) and Sexual and Reproductive Health (SRH) services by the African Youth Alliance (AYA), an initiative in Tanzania (2000- 2005). Some of the many achievements in Tanzania were:

- Increased awareness of the rationale and need for YFS provision
- Strengthened capacity for national-level coordination of YFS
- Provision of services to youth (in Zanzibar) where existing policy did not yet stipulate support for such access. Strengthening of numerous youth-friendly facility efforts were accomplished over the course of the project

- Development of M&E tools and systems used under AYA to improve the facilities
- Strengthening of Management Information Systems (MIS) through training of staff on tools developed under AYA and institutionalized in the facilities

Ethiopia and Kenya

Facilitated referrals have worked well in both Ethiopia and Kenya. Their referral system has been key to their integration efforts as they strived not to lose clients as they were referred from one service to another. In Adama Ethiopia, Home and Community Based Care (HCBC) has been conducted by voluntary caregivers escorting clients to the hospital for services not offered at their nearest clinic. The caregiver also provides follow-up during home visits.

In Kenya, another example of a facilitated referral is the use of referral forms for community health workers (CHWs). The MOH provides each of its CHWs with a referral form to give to clients needing preventive care or FP series, and with its unique serial number it has a section where the CHW indicates the reason for the referral and a section for the action taken by the receiving officer. The form allows for a degree of status to the CHWs in the eyes of the community and making the referral facility accountable for follow up.

In Ethiopia a key success story has been their integration of FP/HIV services in their HCBC programme..

In Kenya, another key success story in their integration efforts has been the quality of health worker training.

(k) Lessons for Botswana integration strategy

- The use of referral forms by community health workers (as done in the countries studied) such as the HEAs and the Lay Counselors will provide a bridge between community members and the facilities to access comprehensive care.
- Integration of SRHR at Home and Community-based care should be explored in Botswana
- Creation of more Youth friendly services at facilities and communities as occur in the countries studied.

From the success stories it can be inferred that not all SRH components are integrated into HIV and vice versa in the countries studied. In Botswana however, the service standards are explicit about delivering the entire package. The MOH plans to implement an integrated strategy that takes into account the entire package of SRHR and HIV as listed in the Policy Standards. Gaps in skills, equipment and supplies will therefore have to be identified and provided incrementally.

It can be observed also from the success stories that the non-health sectors are not very pronounced in the process. In Botswana however there are national and district multi-sectoral structures that can be enhanced to support the integration.

III. The Log Frame

(This is obtainable from Ministry of Health)

IV. Questionnaire Outline

(a) Service Providers

Q1: What service do you provide?

Q2: What is the link between HIV/AIDS and SRHR

What does the linkage mean? Generally and practically to you

Q3: Is the legal and policy environment conducive for integrating HIV/AIDS and SRHR?

What would you have to do differently?

How many clinics?

Q4: Where do you find gaps?

- Policy, Legal, Research, Service delivery, Training, HR/ capacity, Advocacy , Equipment and supplies, other resources, Funding, Infrastructure, Monitoring & Evaluation Indicators and Tools, Gender sensitivity , Partnership

Q5: What model will suit you?

Q6: Values and benefits

Q7: Challenges

Q8: Needs

Q9: Rate the following dimensions of quality 1-5 (1 being the least and 5 being the best)

- Trust
- Access to service
- Availability
- Friendliness of provider
- Privacy

(b) Pilot sites (providers)

Facility type:

Q1: Does your facility provide SRHR or HIV/AIDS or both services?

Q2: What does the package entail?

Q3: How are these provided?

Q4: Are there gaps? (Un-met needs)

- If so how can the gaps be filled?

Q5: Is HIV/AIDS and SRHR services fully integrated at your facility?

- If yes, how?
- If no, why?

Q6: When did integration take place?]

Q7: What have you gained as a service provider?

Q8: What do you think your institution/facility has gained?

Q9: What model are you using?

- What advantages can you talk about?
- What challenges have you encountered?
- State other challenges (reporting, time, etc.)

Q10: Do you have any recommendations to give for improving the integration?

(c) Government/ non-Government Collaborators (MOE, MYSC, UN agencies and others)

Q1: Do you have a SRH or HIV/AIDS programme?

Q2: What value and benefits will you derive if the two are merged/ integrated?

Q3: What arrangement would you propose for such integration: national level, district or facility level?

Q4: What needs do you envisage at these levels?

Q5: What will be your role and contribution to the realization of this goal?

Q6: Do you already have a budget for this integration? Or are you a potential sponsor?

(d) Sponsors; current and potential (UNIADS, UNFPA, UNICEF, EU, PEPFAR, ACHAP etc)

Q1: What value and benefits will you derive if the two are merged/ integrated?

Q2: What sustainable arrangements would you propose for such integration in addition to the prescribed governance?

Q3: Do you think the governance arrangements are sustainable (national, district...)?

Q4: What is your role and contribution towards the realization of the goals of the integration?

Q5: Do you already have a budget or are you a potential sponsor?

(e) Stakeholders In-Depth Interview Guide (Policy & Programme)

Q1: What is the premise/justification for the HIV/AIDS-SRH integration strategy?

Q2: Clearly state the linkages between HIV/AIDS and SRH (where is the link?)

Q3: Do you find the current legal and policy environment adequate for integrating the two programmes?

Q4: What would the value and benefits to users and service providers be?

Q5: What model would you prescribe? (one size fits all or one at each level)

Q6: What are the challenges per facility type?

Q7: Which programmes/ health services?

Q8: Which collaborators?

Q9: Is the capacity for the integration at the facility level adequate (HR, funding, equipment, supplies, etc.)

-If "NO", where are the gaps for obtaining the full complement for the integration?

Q10: Will the tools for monitoring and evaluating and reporting HIV/AIDS and SRH service delivery present a challenge for you?

What about reporting on funding for the two programmes?

Do you recommend an integrated reporting tool?

V. List of Consultations

| Description | Name and Designation | Organisation/Facility | Date |
|---|--|--|---------------|
| Preparatory Discussion Meeting | OM Josephine | UNFPA | |
| Singing of Contract | | UNFPA | |
| Meeting with MOH Director of HIV/AIDS | Dr. Lebelonyane- Director of HIV/AIDS | MOH | 5 March 2012 |
| Meeting with Director of Clinical Services | Dr. Sinvule- Director of Clinical Services | MOH | 6 March 2012 |
| Meeting with the Director of Public Health | Mr. T. Mokgowsanyana- Director of Public Health | MOH | 9 March 2012 |
| Meeting with UNICEF | Dr. Coletta Kibassa | UNICEF | 19 March 2012 |
| Meeting with UNAIDS | Emmanuel | UNAIDS | 19 March 2012 |
| Meeting with I.H.S programme implementers | Onalenna Seitio-Kgokgwe- Deputy Principal Bontlogile L. Ndaba- HOD Public Health Sciences Sandra Manatona- HOD Midwifery Montlennyane Madisa- HOD FNP Yvonne Moathodi- HOD General Nursing | IHS | 21 March 2012 |
| Meeting with BOCAIP | Irene Kwape | BOCAIP | 21 March 2012 |
| Meeting with WHO | Lucy Maribe- | WHO | 23 March 2012 |
| Meeting with SRH Programme Implementers | Dr. Mmakgomo Raesima- Programme Manager, National Cervical Cancer Prevention Programme Ms. Molly Rammipi- Family Planning Programme Coordinator | SRH | 23 March 2012 |
| Meeting with SRH Programme Implementers | Gosatla Rabontheng- ASRH L. Mokhuipuki- CE & E Mabole Masweru- Maternal & new born health | SRH | 23 March 2012 |
| Meeting with Sefhare Primary Hospital staff | | Main staff members Sefhare Primary Hospital | 27 March 2012 |
| Meeting with Otse Health Post Staff | Gertrude Ganetsang- Principal Registered Nurse Lesego Mpodi- Registered Nurse Boikaego Meremeroi- Snr Health Education Assistant | Otse Health Post | 28 March 2012 |
| Meeting with Shoshong Clinic staff | Tebogo Dipogiso- Snr HEA Kagiso Nkgokga- Midwife/PRN Kgomotso Badisong- Midwife/PRN Odireleng Kethaetse- Assistant Nursing Officer Rebecca Kowa- PRN | Shoshong Clinic with Maternity | 28 March 2012 |
| Meeting with Youth Friendly Clinic Staff | Gasethata Mokgadi- PRN Masedi Kebalatetse- SRN Cecilia Feni - NOII | Youth Friendly Clinic Mahalapye | 28 March 2012 |
| DHMT Mahalapye Meeting | Nutrition H.E officer M&E Officer | Programme officers Mahalapye | 29 March 2012 |
| Meeting with DHT | Chedu Tamuthiba- HEO Tshepo Selkle- HEO Mabedi Chose- HOII (nutrition) Tirafalo Gaboslamelwe- DHMT Matron Odumetse Moeletsane- M&E Lefatho Mabutho- C R/W Rebecca Kowa | DHT Mahalapye | 29 March 2012 |

| | | | |
|---------------------------------------|--|--|---------------|
| | Widzani Sello- Nursing Superintendent Tom K. Baaisi- Principal Pharmacist I Dr. K. Banoalis- Head DHMT DR. Bojo- Hospital Superintendent II | Mahalapye District Hospital | 29 March 2012 |
| BONEPWA | David Chizao Ngele | Country Director Gaborone | 29 March 2012 |
| FHI 360 | Barbara Banana Mudanga 71754281 | Deputy Project Director Gaborone | 30 March 2012 |
| Meeting with Men's Sector | Eric K. Mosothlwane- Secretariat Koziba Chibona- Tech Committee Member Edwin Mogatlenyane- Secretariat Joseph K. Mphafe- Secretariat Tebogo Kentstse- Tech Committee Member Kgannang Debego- Tech Committee Member Motshabi C. Kgwatalala- Ex-Officio Seikiso Peowle- Tech Committee Member Ntona Bashanako- MS. Tech Member Alla T. Moyo- MSC/MTTC May M. Ditsela- AIDS Coordinator (BDF) | Men's Sector | 2 April 2012 |
| M&E (HIV) | Tim Chadborn (13h45) 2D1 Dinah | M&E Officers MOH, Gaborone | |
| SMC | Dr. Janet Muambona (14h45) 2F | MOH Gaborone | 3 April 2012 |
| Sesung Health Post | Lillian Botsinle- HEA II Ditiro Mothoyomotona- Nurse | Sesung Health Post Letlhakeng | 4 April 2012 |
| Khudumelapye Clinic | Nkgomotsang Ooke- Health Education Assistant Patricia Wakgotla- PRN Dr. Guy-Eric Kayombo Kamba- Doctor | Khudumelapye Clinic (without maternity) Letlhakeng | 4 April 2012 |
| Letlhakeng Clinic | Chandapiwa Tiro- Counsellor Gaserekwe Ramosesane- PRN Gabotshwandelwe- PRN Betty Mothbagomo- FWE Dr. Kadima Yawkinna- SMO, Cell: 72949487 | Letlhakeng Clinic (with maternity) Letlhakeng | 4 April 2012 |
| CDC Atlanta | Lydia Lu | MOH | 5 April 2012 |
| Meeting with SAT Country Manager | Mr. Thatoyaone- Country Manager | Southern Africa Age Trust Swedish House | 10 April 2012 |
| Meeting with DHMT | Gaialetsang Mnoongo- PRN Wendy Mokoledi- PHCM Keabetswe Pone- N/S Agnes Diseco-CPAO Mmunyane Omphemetse- CHN/PRN Dr. Solomon- Head DHMT | DHMT Kgatleng District | 12 April 2012 |
| Meeting with Technical task team | Stakeholders | MOH | 26 April 2012 |
| Meeting with Technical task team | Stakeholders | MOH | 3 May 2012 |
| Meeting with Technical task team | Stakeholders | MOH | 4 May 2012 |
| Meeting with larger Stakeholder group | Stakeholders | MOH | May 2012 |

VII. Documents Consulted

Adolescent Sexual and Reproductive Health Implementation Strategy. Ministry of Health, May 2003.

AU Campaign on Accelerated Reduction of Maternal Mortality (CARMMA). AFRICA CARES: No Woman Should Die While Giving Life. African Union Commission, 2009.

Botswana Millennium Development Goals: Status Report 2010. The Government of Botswana and the United Nations in Botswana, 2010.

E Bolotse: The Official Newsletter of the National AIDS Coordinating Agency. Prevention of new HIV infections remains the ONLY CHOICE. February 2012.

Maputo Plan of Action, 2006.

Modes of Transmission Study: Analysis of HIV Prevention Response & Modes of Transmission. The Botswana Country Synthesis Report, September 2010.

National and Reproductive Health Programme Framework. Ministry of Health and UNFPA, November 2002.

National HIV and AIDS Research Agenda. National AIDS Coordinating Agency, 2011.

Policy Guidelines and Service Standards: sexual and reproductive health. Ministry of Health, Department of Public Health.

Preliminary Botswana HIV/AIDS Impact Survey III Results: Stats Brief, May 2009.

Sexual and Reproductive Health and HIV/AIDS. A framework for Priority Linkages. WHO, UNFPA, UNAIDS, IPPF. October 2005.

Towards Universal Access by 2010: How WHO is strengthening health services to fight HIV/AIDS. World Health Organization 2010.

VIII. Africa Conventions and Treaties

| Conventions/Declaration/Resolution/Treaty/ Communiqués/ Reaffirmations (Year) | SRH | HIV/AIDS | Ratification by Botswana |
|--|-----|----------|--------------------------|
| 1. Declaration on AIDS epidemic in Africa (Abuja, 1991) | x | x | |
| 2. Resolution on AIDS in Africa (Senegal, 1992) | | x | |
| 3. Tunis declaration on AIDS and the child in Africa (Tunis, 1994) | | x | |
| 4. Resolution on regular reporting of the implementation status of OAU declarations on HIV/AIDS in Africa (Cameroon, 1996) | | x | |
| 5. Establishment of an African fund for AIDS control (Burkina Faso, 1998) | | x | |
| 6. Declaration on the HIV/AIDS Epidemic, XI-ICASA (1999) | | x | |
| 7. Lome declaration of HIV/AIDS in Africa (Lome, Togo, 2000) | | x | |
| 8. Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001) | | x | |
| 9. Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2003) | | x | |
| 10. African Protocol (2003) | | x | |
| 11. Declaration on HIV and AIDS (2003) | x | x | |
| 12. Special Summit of the African Union on HIV/AIDS, Tuberculosis, and Malaria (ATM), Abuja, Nigeria, (2006) | | x | |
| 13. Brazzaville Commitment (2006) | | x | |
| 14. Maputo Plan of Action (2006) | x | x | x |

Global Conventions and Treaties

| Conventions/Declaration/Resolution/Treaty/ Communiqués/ Reaffirmations (Year) | SRH | HIV/AIDS | Ratification by Botswana |
|---|-----|----------|--------------------------|
| 1. CEDAW (1979) and BPFA | x | | |
| 2. Paris Declaration (1994) | x | x | |
| 3. The protection of human rights in the context of HIV and AIDS (2001) | | x | |
| 4. Declaration of Commitment on HIV/AIDS (UNGASS) (2001) | | x | |
| 5. A World Fit for Children (Part of UNGASS) (2002) | x | x | |
| 6. Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and Malaria (2003) | | x | |
| 7. Convention on the Rights of the Child -Adolescent health and development in the context of the convention on the rights of the child (2003) -HIV/AIDS and the rights of the Child (2003) | x | | |
| 8. Women, the girl child and HIV/AIDS (2003) | | x | |
| 9. WHO 3x5 Strategy (2003) | | x | |
| 10. HIV/AIDS and Human Rights (2005) | | x | |
| 11. Call to Action: Towards an HIV-free and AIDS-free generation, Abuja, Nigeria (2005) | | x | |
| 12. United Nations Millennium Declaration (Millennium Development Goals) (2005) | x | x | |
| 13. Political Declaration on HIV/AIDS Review of UNGASS (2006) | | x | |