Republic of Botswana
**MINISTRY OF HEALTH**

# NATIONAL GUIDELINES ON HEALTH SERVICES INTEGRATION

Reproductive, Maternal, Newborn, Child, and Adolescent, Health, +Nutrition, Non-Communicable Diseases & Other Services

**"Making Health Systems Work"**

**December 2021**

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ANC** | Antenatal care |
| **ART** | Antiretroviral treatment |
| **CARMMA** | Campaign on Accelerated Reduction of Maternal Mortality |
| **CBO** | Community-based organization |
| **CHW** | Community Health Worker |
| **CSO** | Civil society organization |
| **DET** | District Extension Team |
| **DHIS** | District Health Information Software |
| **DHMT** | District Health Management Team |
| **DMSAC** | District Multisectoral AIDS Committee |
| **EHSP** | Essential Health Services Package |
| **EID** | Early infant diagnosis |
| **FBO** | Faith-based organization |
| **FNP** | Family Nurse Practitioner |
| **GBV** | Gender-based violence |
| **HAART** | Highly active antiretroviral therapy |
| **HIV** | Human Immunodeficiency Virus |
| **HPV** | Human Papillomavirus |
| **HTS** | HIV testing services |
| **ICPD** | International Conference on Population and Development |
| **IEC** | Information, education and communication |
| **IHSP** | Integrated Health Services Plan |
| **ISD** | Integrated Service Delivery (National Coordinator) |
| **IT** | Information technology |
| **ITC** | Integrated Training Curriculum (National Coordinator) |
| **M&E** | Monitoring and evaluation |
| **MoHW** | Ministry of Health and Wellness |
| **NAHPA** | National AIDS and Health Promotion Agency |
| **NCD** | Non-communicable disease |
| **NDP 11** | National Development Plan 11 |

| | |
|---|---|
| **NSF III** | Third National Strategic Framework on HIV and AIDS |
| **PAC** | Post-abortion care |
| **PEP** | Post-exposure prophylaxis |
| **PHC** | Primary health care |
| **PMTCT** | Prevention of mother-to-child transmission |
| **PNC** | Pre/postnatal care |
| **PTA** | Parent teacher association |
| **RHMT** | Regional Health Management Team |
| **RMNCAH+N** | Reproductive, Maternal, Neonatal, Child and Adolescent Health + Nutrition |
| **SADC** | Southern African Development Community |
| **SDGs** | Sustainable Development Goals |
| **SGBV** | Sexual and gender-based violence |
| **SMC** | Safe male circumcision |
| **SRH** | Sexual and reproductive health |
| **SRHR** | Sexual and reproductive health and rights |
| **SS** | Supportive supervision |
| **STI** | Sexually-transmitted infection |
| **TB** | Tuberculosis |
| **TWG** | Technical working group |
| **UHC** | Universal health coverage |
| **UNFPA** | United Nations Population Fund |
| **VDC** | Village development committee |
| **VHC** | Village health committee |
| **VMMC** | Voluntary medical male circumcision |
| **WHO** | World Health Organization |

# Defining Key Concepts

***Integrated Services:*** The organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, to achieve the desired results and provide value for money.[1]

***Service linkages:*** The relationships between health facilities and other health service providers in a district (or region) that provide services that are needed by patients, but not directly provided by the health facility. According to the World Health Organization (WHO), linkages include: "*The systematic and effective referral of patients and their families from one service to another within the district health system or network. Effective referral systems are important to ensure that a client receives the designated services. Internal linkages between service points are organized within the facility or between clinicians and the pharmacy and lab.*"[2]

***Task shifting:*** The rational redistribution of tasks among health workforce teams, by which specific tasks are moved from highly-qualified health specialists to other qualified and competent health workers in order to optimize efficiency in resource use and service delivery.[3]

***Universal Health Coverage (UHC):*** Ensuring that all people and communities have access to and can use quality promotive, preventive, curative, rehabilitative and palliative health services as they need, without being exposed to financial hardship. UHC enables everyone to access the services that address the most significant causes of disease and death, and ensures that the quality of those services is adequate to improve the health of the people who receive them.[4]

***Health Sector Reform:*** A sustained process of fundamental change in national policy and institutional arrangements led by the Government and designed to improve the functioning and performance of the health sector and ultimately the health status of the population.[5]

***Community-Based Health Services:*** All services provided by qualified and competent health workers who spend a substantial part of their working time in the community discharging their services at the individual, family and community level and linking clients with health facilities for continuity of care. A particular feature of this definition is that it covers all services delivered in communities.[6]

***Primary Health Care (PHC):*** A comprehensive societal approach to health that aims to ensure the highest possible level of health care and well-being. It is premised on the equitable distribution of services by focusing on people's needs and as early as possible along the continuum, from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment. PHC entails three interrelated and synergistic components, which are:

1. Comprehensive integrated health services that embrace primary care, public health goods and functions;
2. Multisectoral policies and actions that address the upstream and wider determinants of health; and
3. The engagement and empowerment of individuals, families and communities for increased social participation and enhanced self-care and self-reliance in health.[7]

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1 WHO (2008) Integrated Health Services, When and Why. Technical Brief No.1, May 2008.
2 WHO (2008) Operations Manual for Staff for delivery of HIV prevention, care and treatment at Primary Health Care Centers -Service integration, linkages and triage.
3 WHO (2008) Global Recommendations and Task Shifting Guidelines.
4 WHO definition. See https://www.who.int/health_financing/universal_coverage_definition/en/
5 Mills, A., S. Bennett, S. Russel (2001) Health Sector Reform and the Role of Government.
6 WHO (2016) Community-based Health Services: a vital part of Universal Health Coverage Universal Health Coverage discussion paper 1.
7 WHO and UNICEF (2021) Factsheet: A vision for primary health care in the 21st century: Towards UHC and the SDGs. https://www.who.int/news-room/fact-sheets/detail/primary-health-care

# PREFACE

Botswana has made great strides to improve the health and well-being of its population, and is committed to achieving the Sustainable Development Goals (SDGs) and Universal Health Coverage. In moving forward to achieve the SDG targets, and in particular SDGs 3 and 5, Botswana is drawing from national, regional and global learning and emerging best practice to build current and future initiatives, implementation guidance and recommendations.

The Government has adopted Integrated Sexual and Reproductive Health and Rights (SRHR)/ HIV Services as a national strategy, following a successful pilot undertaken as part of the United Nations Population Fund (UNFPA) and UNAIDS supported 'SRHR/ HIV Linkages' pilot project (2011-2015). Subsequently, the national SRHR/HIV Scale-up Plan was developed, with the objective of increased access to and use of a broad range of quality services for sexual and reproductive health (SRH) and HIV prevention, treatment, care and support, with linkages to sexual and gender-based violence (SGBV). This was aligned to strategic guidance provided through Chapter 9 of 'Vision 2036: National Development Plan 11' (NDP 11) on Social Upliftment, as well as the Integrated Health Services Plan (IHSP). The IHSP operationalizes the 2010 National Health Policy, and the Ministry of Health and Wellness (MoHW) Strategy (2017-2023) is aligned to it. Other integration strategies have also been considered, given the indisputable benefits of delivering integrated health care.

The ultimate goal of the approach to the provision of health services in an integrated manner is to institutionalize linkages and the integration of client-focused services, so as to synergistically address health challenges within the context of a PHC approach. Botswana has embarked on health sector reforms that include ensuring that the client-centred or -focused integration agenda is aligned to the PHC principles of comprehensiveness, coordination, community participation and sustainability.

In 2017, through a Botswana Government National Commitment Letter, MoHW committed to the Global Strategy for Women's Children's and Adolescent's Health (2016-2030). Following this commitment, the Botswana Integrated Reproductive, Maternal, Newborn, Child and Adolescent's Health (RMNCAH+N) Strategy (2018-2022) was developed. The integration agenda embraces the PHC approach, and is anchored in the RMNCAH+N Strategy. In so doing, it broadens the scope of integration to include other health diseases and conditions such as non-communicable diseases (NCDs), which are estimated to contribute to 46 percent of all deaths in Botswana.[8] This constitutes a fundamental shift, from vertical clusters of integrated programme models, to a comprehensive approach that focuses on the client in a holistic manner.

Health care reforms in Botswana have focused on strategies to improve health outcomes through initiatives aimed at improving the quality and cost-effectiveness of health services. This is part of a broader strategy to achieve the SDGs and UHC in the face of declining development partner support and the need to transition to domestic financing.

[8] MoHW (2018) Botswana Multi-Sectoral Strategy for Prevention and Control of NCDs (2018-2023).

To achieve meaningful UHC, a shift is needed from health systems designed around diseases and institutions, to those designed *for* people, *with* people. The PHC approach demands that the Government recognises and commits to moving beyond the health sector and mainstreams a government-led approach to health in all aspects of development, including non-health policies, with a strong focus on equity and interventions that encompass the entire life cycle.[9]

According to MoHW, integrated health services are expected to cluster the functions related to public health, clinical services, HIV and AIDS and other vertically-implemented programmes. This is expected to promote the integration of services and continuum of care for: patient care, management and safety; disease control; SRH; child and adolescent health; nutrition and food control; oral and dental health; mental health; and emergency medical services.[10] This is underscored in the MoHW mission statement: "To promote and provide integrated, holistic and sustainable preventative, curative, rehabilitative quality health service to the nation".[11]

The purpose of these National Guidelines on Health Services Integration is to provide strategic guidance for positioning integrated service delivery as a health development imperative. These guidelines provide suggestions on how to transition to a systematic response to the health needs of individuals, families and communities, in a client-centred manner, whilst following a set of standards and protocols for each service. This is expected to protect safety and quality interests, so as to optimize and exploit opportunities across all levels of care, in all settings (private, public or civil society).

These guidelines will support all health service providers from public, private and civil society health care settings to provide holistic, client-centred integrated services that prioritize people's health needs. The guidance is organized into five substantive components:

1. **GOVERNANCE, COORDINATION AND ACCOUNTABILITY**
2. **PREPARING DISTRICTS FOR TRANSITION TO INTEGRATED SERVICES**
3. **REORIENTING FACILITIES TO PROVIDE A PERSON-CENTRED SERVICE**
4. **MONITORING AND EVALUATION**
5. **CRITICAL ENABLERS**

[9] See WHO: https://www.who.int/news-room/fact-sheets/detail/primary-health-care
[10] See: https://www.gov.bw/ministries/ministry-health-and-wellness
[11] Ministry of Health and Wellness Strategic Plan (2017-2023).

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Finally, special thanks go to UNFPA, especially the SRHR/HIV and SGBV Coordinator Ms. Kesaobaka Dikgole, for her able oversight and provision of technical and financial support towards the finalization of the health services integration guidelines. These Guidelines will go a long way in ensuring that all people living in Botswana receive integrated services thus improving access and service uptake.

I thank you.

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# 1 SECTION

# INTRODUCTION and CONTEXT

# 1.1 INTRODUCTION

**THE GOVERNMENT OF BOTSWANA** is committed to ensure that all Batswana live long and healthy lives, have access to health care services of the highest standard and are able to pursue healthy lifestyles.[12] To achieve this goal, Botswana is shifting the health system towards universal health coverage, through equitable access to quality health services. These services are integrated, safe and people-centred across the continuum of care,[13] within the context of an overarching primary health care approach.

## 1.1.1 Strategic documents and frameworks informing the Guidelines

In line with global, regional and national policy frameworks, Botswana is committed to leave no one behind in health, and is scaling up the provision of client-centred, integrated health care services. Botswana is a member of different bodies at global and regional levels, and signatory to various international and regional conventions, protocols and commitments that seek to improve health outcomes for all, especially women, young people and children.

These guidelines are aligned to and informed by various relevant global, regional and national policy frameworks, as set out in Table 1, p. 15.

In moving forward to achieve the SDG targets... **SDGs 3 and 5**, Botswana is drawing from national, regional and global learning...

[12] Government of Botswana. 2016. Vision 2036: Achieving prosperity for all.
[13] See WHO: https://www.who.int/teams/integrated-health-services

**Table 1: Relevant policy frameworks**

| Level | Policy Framework | Relevance to Guidelines |
|---|---|---|
| **Global** | Sustainable Development Goals | » Goal 3 (*Ensure healthy lives and promote well-being for all at all ages*) on reducing maternal and child mortality, preventing early and unwanted pregnancies, ending the epidemics of HIV and tuberculosis (TB), combating hepatitis, malaria and NCDs, achieving UHC, and promoting mental health and well-being.<br>» Goal 5 (*achieve gender equality and empower all women and girls*) on the elimination of violence including sexual violence against girls and women in all settings, elimination of harmful practices such as early and forced marriages, and increasing access to SRHR in accordance with the Programme of Action of the International Conference on Population and Development (ICPD), as well as the Beijing Platform for Action. |
| | Global Strategy for Women's, Children's, and Adolescent Health (2017) | » Botswana committed to the Strategy and its guiding principles and further pledged to undertake sustainable actions consistent with the SDGs above, to accelerate the health of women, children and adolescents. |
| **Regional** | Agenda 2063 Maputo Plan of Action (2016-2030) Strategy for SRHR in the SADC Region 2019-2030 | » Provides a policy and programming framework for accelerating the attainment of SRHR for all people living in the region.<br>» Desired outcomes 7-8 include universal access to integrated SRH services. |
| | African Union | » Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) 2009-19.<br>» Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. |
| | Revised SADC Protocol on Gender and Development (2016) | » Aims to provide for the empowerment of women, to eliminate discrimination and to achieve gender equality and equity through the development and implementation of gender-responsive legislation, policies, programmes and projects. |
| | Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the in the SADC Region (2015) | » Defines the minimum package of services to be offered to a client based on the reason for their visit to a health facility. |
| **National** | Vision 2036[14], and National Development Plan 11 | » Pillar 2 (Human and Social Development). Chapter 9 (social upliftment) of NDP 11 identifies enhancing the integration of health services in priority areas such as: HIV, TB, SRHR, mental health, maternal and child health and rehabilitation, measures towards the prevention, treatment, rehabilitative and palliative care for those affected by NCDs, and revitalization of PHC as a key strategic approach to be adopted for achieving health goals and targets. |

[14] VISION 2036 – Achieving Prosperity for All (Presidential Task Team, July 2016)

Table 1 (cont'd)

| Level | Policy Framework | Relevance to Guidelines |
|---|---|---|
| *(cont'd)* **National** | Botswana Integrated Health Services Plan (2010) | » Currently under review. |
| | Essential Health Service Package for Botswana (EHSP) (2010) | » Under review. An integrated collection of cost-effective interventions that address the main diseases, injuries and risk factors that affect the population. EHSP aims to harmonize and align health sector planning. The concept of EHSP is to ensure the total integration and harmonized delivery of all services. It provides a standardized package of basic services, which forms the core of service delivery in all PHC facilities. It also promotes the redistribution of health services by providing equitable access, especially in underserved areas and populations such as women, children, adolescents, the elderly and for all people resident in Botswana. |
| | Third National Strategic Framework on HIV and AIDS (NSF III) Enhancing Efficiencies through an Integrated Approach (2018-2023). | » NSF III seeks to expand an integrated approach to the delivery of HIV and AIDS services to ensure efficiency in critical areas such as human and financial resources, and increase service coverage. NSF III also aims to strengthen coordination of the multisectoral HIV response with emphasis on 'one monitoring and evaluation (M&E) framework' for the national HIV response. |
| | Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Strategy (2018–22) | » MoHW departments, divisions or units for SRH/ HIV/ Prevention of Mother-to-Child Transmission (PMTCT)/ Child Health and Nutrition have several policies, strategies, frameworks and guidelines in existence to guide the provision of quality RMNCAH+N and other services in Botswana. These provide direction, key actions and specific activities for each RMNCAH+N programme area. |
| | Framework for the In-service Training Curriculum for Integrated Health Services (2016) | » Developed to address inefficiencies, duplication and staff shortages occasioned by health care providers being absent from their work stations because of multiple programme specific training activities, amongst other reasons. |
| | Botswana SRHR and HIV and AIDS Linkages Integration Strategy and Implementation Plan | |

Botswana has reaffirmed its commitment to, and domesticated, Agenda 2063 and other instruments, strategies and protocols.[15] However, it is worth noting that, while strides have reportedly been made in some areas, momentum and progress are still to be seen in others, which ultimately impacts the achievement of the SDGs and Agenda 2063.[16] Better data collection would help to strengthen accountability and the accurate presentation of Botswana's implementation status.

[15] See: https://au.int/en/pressreleases/20191123/

[16] See, for example: Daily News (2020) Botswana to Report On Agenda 2063 Progress https://allafrica.com/stories/202002060150.html; Scorecard for SRHR in the SDAC region; SADC (2016) Gender and Development Monitor.

### 1.1.2 Rationale

**Box 1: Definition of an integrated client-centred approach**

WHO defines an integrated client-centred approach as one which ensures that all people have access to health services that are provided and coordinated around their needs, respect their preference, and are safe, effective, timely and affordable and of acceptable quality.

Scaling up and enhancing the provision of integrated HIV, TB, RMNCAH+N services, while managing other communicable diseases and implementing the Botswana NCD Strategy, will be key to reaching the aspirations of NDP 11, to ensure that all people can access comprehensive services and allow for improved patient monitoring and follow-up. The goal of the National Health Policy of Botswana is to, "create an enabling environment in which all Batswana have the opportunity to achieve and maintain the highest standard of health and well-being".[17] This includes ensuring that universal coverage is achieved for all people, based on a comprehensive package of essential health services that includes HIV and AIDS, TB, reproductive and child health.

The United Nations high-level UHC meeting, held in 2019, highlighted the renewal and implementation of PHC as the cornerstone of a sustainable health system and the health-related SDGs. The meeting also highlighted the contribution of UHC to national and global health security, and stated that "health systems should be fit for people, fit for context and fit for purpose."

The IHSP (currently under review) provides the vision to improve the health status and health care for all people in Botswana by 2020.[18] It anticipates that all people will have the opportunity to achieve and maintain the highest standard of health and well-being. The integration of services is expected to ensure that every entry point is used to improve the health of people.

The integrated health services approach is expected to accelerate efforts to achieve the SDG targets of reducing maternal mortality, ending AIDS, TB and malaria, eliminating gender-based violence (GBV) and ensuring universal access to care. It will also accelerate traction in the prevention and control of NCDs, which cause an estimated 46 percent of all deaths in Botswana.[19] The Botswana Multi-Sectoral Strategy for the Prevention and Control of NCDs (2018-2023) identifies NCDs as a threat to achievement of the SDGs.[20]

The comprehensive delivery of integrated services, within the context of the continuum of care approach, recognizes that providing preventive, promotive and curative interventions throughout the life cycle is the most effective way to reduce mortality and improve health outcomes.[21] It is generally recognized that health, especially SRHR, is a precondition for, as well as an outcome and indicator of, all aspects of sustainable development. This includes ensuring: that the family planning needs of women of child-bearing age are met with modern methods (SDG 3.7); as well as universal access to sexual and reproductive health and reproductive rights, in accordance with

17 Government of Botswana (2011) National Health Policy: Towards A Healthier Botswana. Ministry of Health. Botswana.
18 Ministry of Health and Wellness 2010- Integrated Health Service Plan: A Strategy for Changing the Health Sector For Healthy Botswana 2010-2020.
19 WHO (2016) Causes of death in Botswana.
20 Government of Botswana (2018) Multi-Sectoral Strategy for the Prevention and Control of NCDs 2018-2023.
21 WHO (2019) Analysis and Use Of Health Facility Data- Guidance for RMNCAH programme managers.

the ICPD Programme of Action and the Beijing Platform for Action, and the outcome documents of their review conferences (SDG 5.6).

These indicators align with those of the SDG Framework. A core tenet of the Strategy is to ensure that no one is left behind, despite the fact that people's health needs are diverse, unique and health care should be tailored to their stage of development and time of life. Inherent in the principle of leaving no one behind is the purposeful identification of vulnerabilities, including older people, orphaned children, people with disabilities, as well as those living in poverty. This aligns with the PHC principle of inclusivity, which is the practice of ensuring equal access and opportunities for all, including those who could be marginalized because of their geographical location or ethnicity. The integration of health services seeks to link to, and ensure coordination and synergy with, children's and women's rights networks.

### 1.1.3 Benefits of comprehensive integrated health service delivery as reported by clients and health care providers

Some of the lessons learnt from the 'SRHR/HIV Linkages' project emerged from the 2016 Customer Satisfaction Survey, in which both providers and clients welcomed integration and appreciated its advantages and convenience. Table 2 below illustrates the benefits of a comprehensive integrated health service delivery as reported by both clients and health care workers in this survey.[22]

**Table 2: Comprehensive integrated health services delivery**

| |
|---|
| » Saves time for the client and the health worker by reducing the frequency of visits to seek different services and waiting times |
| » Reduces missed opportunities to receive services |
| » Increases client satisfaction |
| » More cost-efficient |
| » More effective |
| » Reduces transport costs |
| » Improves client-health worker relationships (kiosk) - element of trust |
| » Improves health outcomes |
| » Reduces stigma and discrimination |
| » Reduces mortality and morbidity (SDGs) |
| » Reduces burn out to staff |

[22] Botswana MoHW (2016) Client Satisfaction Survey Conducted in Pilot Health Facilities Implementing SRHR / HIV Linkages Project.


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### 1.1.4 Purpose of the Guidelines

These Guidelines provide broad guidance on the actions and processes that need to be undertaken to minimize missed opportunities and respond holistically to all health needs of clients or patients. The guidance also suggests minimum service packages for different levels of care, aligned to the EHSP. These are minimum service packages that support health facilities to determine what to offer to which clients, based on their capacity.

The Guidelines suggest a road map for integrating services within the PHC context. The sequencing of the steps in the road map is dependent on the nature of the facility and the unique characteristics of the community and health catchment area it serves. The guide further suggests services that can be provided at different service points, as well as service packages for different levels of the integrated care model.

### 1.1.5 Audience for the Guidelines

These Guidelines are intended to be used by a broad range of stakeholders, with the primary audiences being health care providers and managers in public, private and civil society settings, as the primary care givers. Secondary audiences would be the consumers, beneficiaries and funders of health services. Others include governance structures, such as the National Reference Committee or the RMNCAH+N technical working groups (TWGs) at national and district/ regional levels.

# 1.2 THE APPROACH AND EVIDENCE FOR INTEGRATED CLIENT-CENTRED HEALTH SERVICES IN BOTSWANA

## PROVIDING client-centred integrated health care services demands that every entry point puts the health of people first.

This includes ensuring that all women, in particular adolescent girls and young women, are provided with proper counselling and support so that they can choose which contraceptive method they wish to use to prevent unintended pregnancies, sexually transmitted infections (STIs) and HIV. It calls for all people, irrespective of their gender, sexuality and sexual behaviours, to know their HIV status, and get screened for STIs and TB. Where the need arises, people should be initiated on treatment and supported to adhere. Integration should also contribute to the reduction of maternal mortality by ensuring that all steps are taken to end preventable maternal deaths and screen for NCDs.

Embedded into integrated health service delivery is a rights-based approach, aligned to the MoHW Patients Charter[23] and other frameworks, including the Convention on the Rights of Persons with Disabilities.[24] Borrowing from the Botswana Sexual and Reproductive Health Policy Guidelines and Service Standards,[25] client rights include:

- Right to factual and scientific information on health.
- Right of access to services regardless of social status, economic situation, religious affiliation, ethnic origin, marital status, geographic location, gender or sexual orientation.
- Right to choose SRH services.
- Right to safety in health care delivery.
- Right to privacy during discussions or medical examination.
- Right to confidentiality. Information provided must not be communicated to anybody without consent, but counselling should strive for shared confidentiality.
- 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 to continuity of care, services and commodities.
- Right of opinion. To express their views on the type of services they receive.

[23] MoHW: https://www.moh.gov.bw/Publications/rights_responsibilities.pdf
[24] United Nations (2006) The Convention on the Rights of Persons with Disabilities.
[25] Government of Botswana, MoHW: Policy guidelines and service standards - Sexual and Reproductive Health.

The integration approach is rooted in meeting the needs of clients, and listening to the voices of health care workers on what works or not. Findings from the evaluation of the pilot project to link SRH and HIV services, undertaken between 2011 and 2017, show that more than 80 percent of clients want to receive comprehensive integrated services in a one-stop centre that meets their needs. They say that integration reduces waiting time, decreases the number of trips they make to the health facility, and decreases stigma and discrimination. They also consider that integrated services improve scheduling, referrals, linkages with the community, M&E and the quality of services. The Client Satisfaction Survey showed that over 80 percent of clients want to receive comprehensive integrated services that meet their needs, provided in one place.[26]

Health care workers say that integration promotes efficiency in service delivery as all the services are provided in one visit. The time spent on consultations after an initial assessment is further reduced, as each builds on previous consultations. The lessons from this and other experiences, coupled with global and regional guidance, have informed MoHW health sector reforms including the invigorated PHC approach to health care delivery.

Botswana has been implementing different models of integration appropriate to the level of service delivery. The models were piloted through the 'SRHR/HIV Linkages' project that provided insights, lessons learnt and evidence for the scale-up of integrated services. These models include:

- **Kiosk Model** – applied at health posts and smaller clinics where a number of services were provided within the same room by the same health care provider.
- **Supermarket Model** – a similar approach to the kiosk model but in a physically larger clinic with a number of rooms providing different services from different health care professionals. Referrals may or may not be common.
- **Mall Model** – applied in primary and general hospitals, where different services were provided in different rooms by different health care providers, referrals across rooms or units are inevitable at this level.

The Handbook of the Botswana 2016 HIV Integrated Clinical Care Guidelines gave further traction to the integration of SRHR and HIV services. This was followed by the development of the RMNCAH+N Strategy which broadened the scope of integration. Guidance for other programme- and service-specific efforts that are client-centred and seek an integrated modality include (but not limited to):

- the e-Health Strategy (2020-2024);
- the MoHW Strategic Plan (2017-2023);
- the School Health Strategy;
- the Third National Multisectoral HIV and AIDS Response Strategic Framework (2018-23) "Enhancing efficiencies through an integrated approach";
- the Botswana Integrated HIV and AIDS Basic Services Package; the harmonization of Botswana's CHW Groups;
- the National Guideline for Implementation of Integrated Community Based Health Services;
- the Botswana Health Data Collaborative Road Map "Towards a Harmonized Health Information and Monitoring and Evaluation System in Botswana".

These have been generated over time, in an effort to improve service quality, access and efficiencies.

[26] Government of Botswana, MoHW (2016) Client Satisfaction Survey Conducted in Pilot Health Facilities Implementing SRHR / HIV Linkages Project.

# 1.3 BOTSWANA'S PACKAGE OF INTEGRATED HEALTH SERVICES

**THE CLIENT-CENTRED APPROACH** to integrated SRHR services aims to ensure that every interaction between the client and the health care system is used to prevent ill-health, screen or test people to determine their health status, and ensure that those in need are investigated and initiated on the appropriate treatment.

The previous sections provided an overview of the policy directions and evidence behind the provision of integrated services. As noted, the IHSP aims to ensure that all clients receive an integrated package of services. The EHSP, also under review, details a standardized package of basic service provision. These services form the core of service delivery and are intended to become the cornerstone for health service provision, including preventative, curative and rehabilitative care. The successful implementation of the EHSP, in the context of UHC, is expected to: improve access; reduce referrals and unnecessary delays; enhance equity; and promote the utilization of health services.[27] The basic service packages proposed by the guidelines align with the EHSP, which details the interventions and services for each programme or sub-programme.

While most clients prefer to receive integrated health services, many opportunities to ensure that clients are offered additional services are lost. Services provided under various programmes or specific interventions should always follow defined standard operating procedures in order for clients to derive the benefits of quality and impactful care. While service delivery will be integrated, services will be delivered in accordance with set practices, protocols and guidelines to safeguard the expected quality.

Service integration efforts within the health sector to date have been described by stakeholders as rather "piecemeal", resembling vertical delivery, with combinations such as HIV/TB; SRHR/HIV, SRHR/HIV/SGBV, HIV/TB/Malaria, HIV/SRHR/NCDs etc.

### 1.3.1 From client-initiated to provider-initiated services

One of the fundamental changes in the delivery of integrated services is the need for health care workers to adopt a provider-initiated approach to help clients identify their unmet needs. It is important that, as facilities transition

[27] Botswana Ministry of Finance and Economic Development (2017) National Development Plan 11(2017-2023).

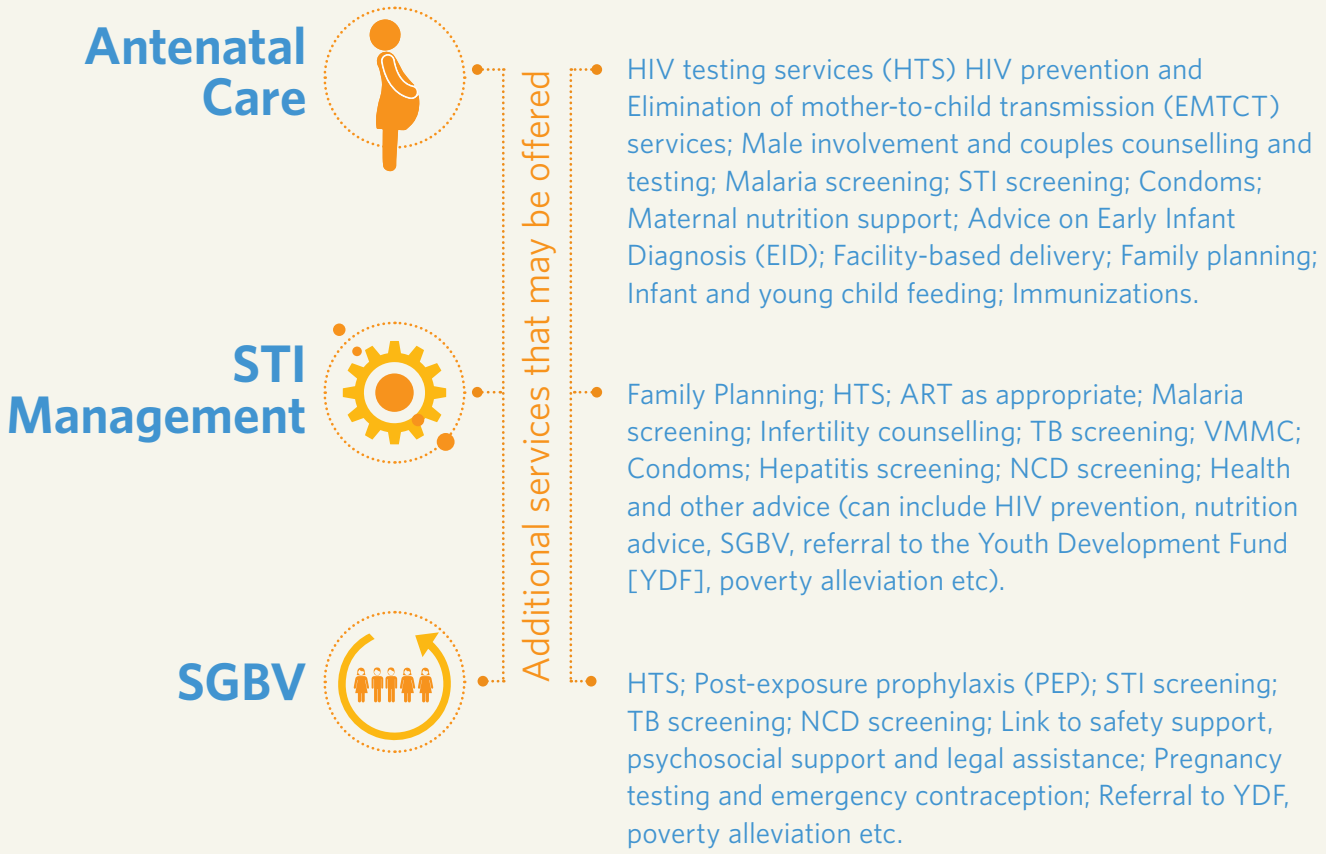
to providing integrated services, health care workers practice prompting clients to take up services beyond those initially sought.

For example, if a client comes in for long-acting contraceptives, she could be asked whether she wants to be screened for STIs, or offered an HIV test and if positive initiated on treatment. An uncircumcised male client that presents with an STI should be asked whether he has considered voluntary medical male circumcision (VMMC), offered a test for HIV and if positive initiated on treatment. A woman living with HIV should be offered family planning when coming in for her antiretroviral treatment (ART) refill.

**Hint:** Do not wait for the client to ask. Offer them the additional relevant services that meet their needs.

Figure 1 below provides examples of options (scenarios) for services that may be offered as patients present for other services at different points of care.

**Figure 1. Scenarios of services that may be offered**



# SECTION 2

## The GUIDELINES

# 2.1 GOVERNANCE, COORDINATION AND ACCOUNTABILITY

**TEAMWORK** is one of the MoHW core values. Moving to client-centred integrated health services involves a team effort, involving everyone from the facility security guard, to the coordinator of the Regional Health Management Team, to the Permanent Secretary.

Integrated health service delivery, in the context of PHC, is a national strategy that seeks to integrate RMNCAH+N and other services as a means to achieve UHC and health SDGs and related targets.

This section outlines the roles and contributions of each element of the health care system to ensure that there is a coherent, coordinated and integrated approach to planning, monitoring and delivery of client-centred integrated services, in all settings, at all levels of the health system. Figure 2 outlines the key roles at each level:

**Figure 2: Coordination structures at all levels**

| | |
|---|---|
| **Strategic Level** | • **National Reference Committee**<br>• Chair - Deputy Permanent Secretary Prevention<br>• Secretarial Services - Integration Coordinators (Integrated services and in-service training curriculum) |
| **Technical Level** | • **RMNCAH+N Technical Working Group**<br>• Chair - alternates between Advisor Community Health Services (CHS) and Consultant PHC<br>• Secretarial Services - CHS |
| **District Level** | • **Integrated Health Services Team**<br>• Programme Coordinators<br>• Leadership of Head of Programmes or as determined |
| **Regional Level** | • **Designated Regional Integrated Services Coordinators**<br>• Head of Preventive Services or Community Health Nurse<br>• Review Committees<br>• Programme Coordinators, chaired by Head of Preventive Services |

### 2.1.1 National level

#### 2.1.1.1 The Ministry of Health and Wellness

MoHW, through the Department of Health Services Management, oversees the national effort to provide client-centred, quality, integrated services. These efforts are coordinated through a mechanism that includes a national coordinator, in partnership with development partners, the private sector and civil society, working through the National Reference Committee and the RMNCAH+N Technical Working Group. As with any reform initiative, transitioning to integrated service delivery should be leader-driven at all levels of health care.

To strengthen accountability and performance development, plans should reflect how health care workers will deliberately work to ensure the envisaged integration through collaboration, planning and delivery actions. Supervisors or managers at all levels will be responsible for ensuring that this is done.

RMNCAH+N, NCDs and other programmes within MoHW have overall responsibility for oversight and the provision of technical leadership, which includes:

- Informing health policies, management and coordination of efforts to strengthen the PHC service-delivery system to deliver client-centred integrated services.
- Developing, managing, coordinating and monitoring the provision of client-centred integrated services at all levels.
- Advocating, mobilizing and sustaining increased domestic and other resources to support the provision of client-centred integrated health care services.
- Including and ensuring that the efforts of relevant stakeholders (the National AIDS and Health Promotion Agency [NAHPA], development partners, CSOs and the private sector) are aligned with national health plans.
- Joint planning, budgeting, M&E of client-centred integrated health services.
- Undertaking operational research to measure the progress made, gaps and the quality of integrated services.
- Sensitizing, orienting, mentoring and capacity-building of Regional and District Health Management Teams (RHMT/ DHMTs) to implement the client-centred integrated health service approach.
- Capacity-building of RHMT/DHMTs to understand their role, and provide quality support to facilities that are transitioning to providing quality integrated services.
- Strengthening human resource capacity to provide quality integrated client-centred services, including deployment, retention, capacity-building, task-shifting/ sharing and block-booking policies.
- Advocating for and developing an integrated national data collection system that incorporates key variables from health services and programmes.
- Reporting to MoHW management, bilateral and multilateral development partners, stakeholders and the people of Botswana on progress made with the delivery of integrated services.

#### 2.1.1.2 The National RMNCAH+N and Other Services Reference Committee

The national RMNCAH+N and Other Services Reference Committee guides and coordinates the process of delivering client-centred integrated services.[28] The Committee, a high-level structure, is chaired by the Permanent Secretary and comprises management representatives of different line functions in MoHW and NAHPA, as well as the leadership of key national CSOs or civil society networks that play a role in integrated service delivery and

[28] The terms of reference for this Committee are included as Annex A.

M&E, and development partners. The work of the Committee is facilitated by the National Coordinators for Integrated Service Delivery (ISD) and Integrated Training Curriculum (ITC), with support from the TWG, and includes:

- Overseeing the development, implementation, M&E of the national effort to provide client-centred integrated health care services.
- Coordinating, harmonizing and enabling interagency support to the national scale-up plan to providers of client-centred integrated services.
- Contributing towards the development and review of policies, guidelines and strategies.
- Monitoring the roll-out of client-centred integrated services.
- Ensuring human resource availability and development to support the provision of integrated services.
- Ensuring that the necessary equipment, supplies and commodities are made available to support the provision of integrated services.
- Facilitating the representation of Botswana in regional and international fora to highlight progress made and lessons learned, and share experiences on client-centred integrated service delivery.
- Guiding allocation decisions to ensure that health reforms and prioritized strategies are adequately resourced.

#### 2.1.1.3 The RMNCAH+N Technical Working Group

The TWG is responsible for providing technical guidance for the day-to-day management, coordination, implementation, M&E of client-centred integrated service provision. The TWG is co-chaired by the Community Health Services Advisor and the PHC Services Consultant or their equivalents. It comprises programme managers from RMNCAH+N and other communicable and non-communicable diseases, as well as PHC managers and programme managers representing CSOs and the private sector, gender and development, and M&E officials. The roles of the TWG include:

- Developing, implementing, monitoring and evaluating the national effort to provide client-centred integrated services.
- Supporting the development of an integrated national annual work plan, budget and M&E plan.
- Submitting annual progress reports to the National Reference Committee.
- Identifying, mobilizing and coordinating the efforts of international institutions, the private sector and CSOs to provide technical and financial support.
- Supporting and coordinating in-service human resource development related to integrated service delivery under the leadership of the Integrated Curriculum Training Coordinator and in collaboration with RHMTs.
- Advocating for and participating in the development of a harmonized, integrated national data collection system that incorporates the linkages between services.

#### 2.1.1.4 The National Coordinator for Integrated Service Delivery

The ISD National Coordinator has responsibility to work across all programmes to ensure that integrated services are well coordinated and anchored in the priority PHC approach. This position, together with the ITC National Coordinator, ensures cohesive and coordinated support for CSOs, the private sector and RHMTs/ DHMTs as they transition to a comprehensive integrated service delivery modality.

The ISD National Coordinator is responsible for the following activities in relation to the national effort to provide client-centred services:

- Advocating for and coordinating the development of an integrated annual work plan and budget.

- Advocating for the resources required to advance the integration agenda, including finance, equipment, commodities, medicines and integrated and harmonized M&E platforms.
- Collaborating with the ITC National Coordinator to build the competencies required for integrating services.
- Jointly with the ITC National Coordinator, serving as a focal point for the National Reference Committee Secretariat.
- Monitoring and reporting on progress in relation to the work plan and budget, providing progress reports to MoHW, the Reference Committee and the TWG, and ensuring follow-up on the recommendations emanating from these.
- Maintaining an updated inventory of relevant ministries (education, gender, youth etc.), bilateral and multilateral development partners, non-health bodies and umbrella institutions, and private sector actors.
- Coordinating the provision of technical support to RHMTs and CSOs, in collaboration with the ITC National Coordinator and PHC Division, to provide client-centred integrated services including participating in the development and implementation of annual regional integration plans, capacity-building and supportive supervision.

#### 2.1.1.5 The National Coordinator for the in-service Integrated Training Curriculum

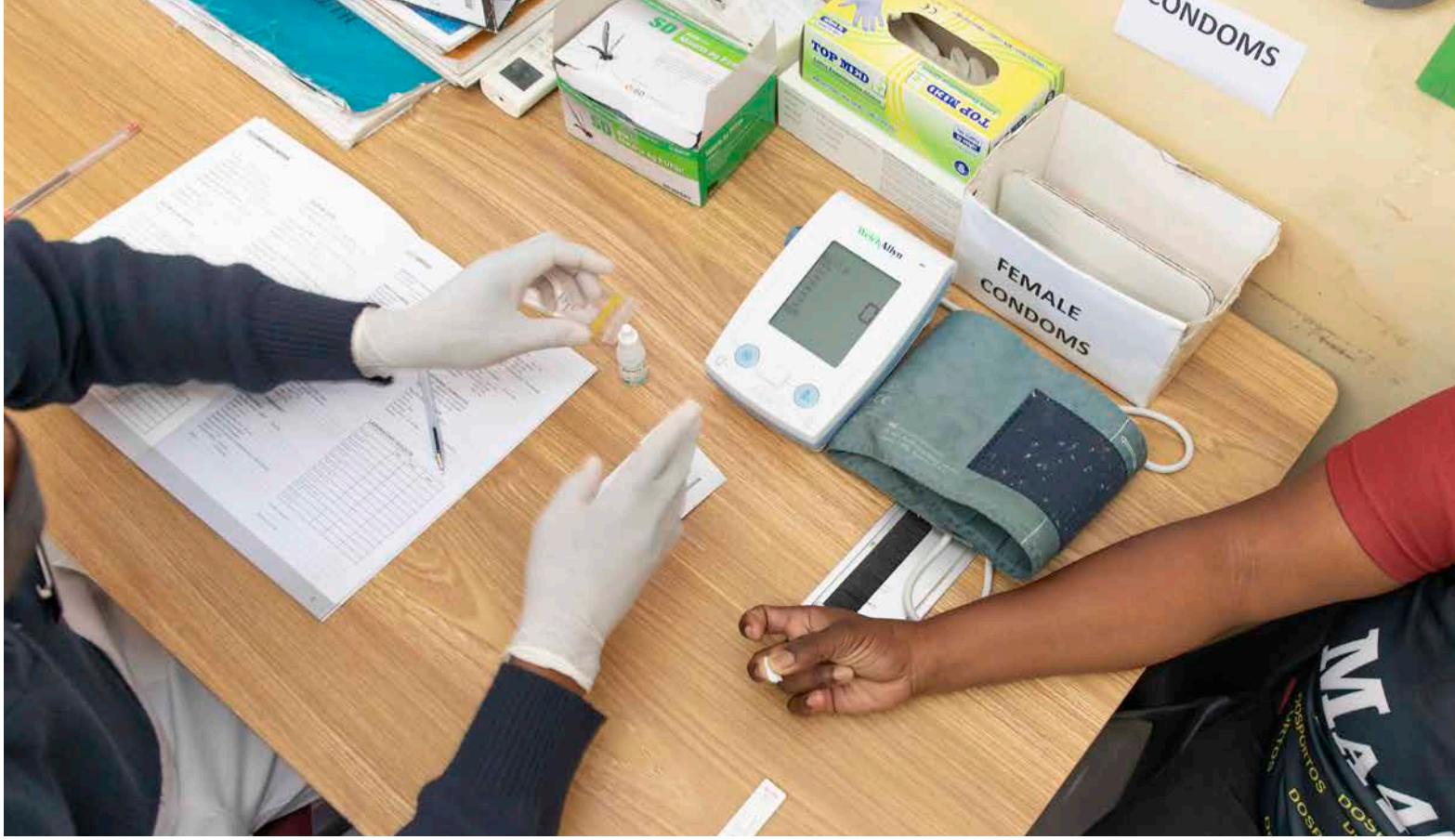
The ITC National Coordinator has responsibility to work across all programmes, ensuring that in-service training is well coordinated. The position, jointly with the ISD National Coordinator, ensures coordinated capacity-building for CSOs, the private sector and RHMTs as they transition to a comprehensive integrated service delivery modality. The ITC National Coordinator is responsible for the following activities in relation to the national effort to build capacity for providing client-centred services:

- Advocating for and coordinating the development of an integrated annual work plan and budget for training.
- Advocating for the resources required to advance the integration agenda and setting up and maintaining an electronic database on training.
- Serving as the focal point, jointly with the ISD National Coordinator, for the Secretariat of the National Reference Committee and the RMNCAH+N TWG. Monitoring and reporting on progress made in relation to the work plan and budget, providing progress reports to MoHW, the Reference Committee and TWG, and ensuring follow-up on the recommendations emanating from these fora.
- Working with RHMT/DHMTs to conduct skills audits and advocating for rationalized, equitable distribution of trained human resources.
- Working in collaboration with RHMT/DHMTs to conduct training needs assessments and maintaining an updated inventory of trained practitioners per health region or district.
- Coordinating provision of training support to RHMTs and CSOs, in collaboration with the ISD National Coordinator and PHC Department, including participating in the development and implementation of annual and regional training plans.

### 2.1.2 District and regional levels

#### 2.1.2.1 Regional and District Health Management Teams

Comprehensive integrated service delivery that is gender sensitive, customer friendly, and client- or patient-focused happens at the regional and district levels. RHMTs are responsible for overseeing the delivery of quality, integrated client-centred health services within their regions. This includes supporting health facilities, hospitals, clinics, health posts and mobile stops, as well as community-based services. In order for change to happen, it has to be managed

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and leader-driven. To strengthen accountability, Performance Development Plans (PDPs) should reflect how health care workers will deliberately work to ensure the envisaged integration actions of joint collaboration, planning and delivery. Supervisors are responsible for ensuring that this happens, as they support health care workers in developing their performance development plans.

Each RHMT should establish an Implementation Team, led by the RHMT Coordinator or DHMT Head. The Implementation Team should comprise key staff members as determined by management, including the Head of Curative Services (responsible for hospital services), the Head of Preventative Services (responsible for the coordination of all programmes and the management of clinics), the Head of Nursing (responsible for capacity-building, placements and transfers of health care workers), the Head of Corporate Services (administration, transport and supplies), cluster heads or managers, programme focal points and coordinators, and the M&E Officer. The Implementation Team should:

- Collaborate with the ISD National Coordinator to arrange orientation for RHMT managers, including a walk-through.
- Develop a joint annual action plan to support health facilities to transition to integrated delivery.
- Maintain an updated inventory of stakeholders (including civil society and other health service organizations) and engage with them on the provision of client-centred integrated services.
- Identify the appropriate model of integration to be applied based on the nature of the health facility.
- Support facility heads to undertake facility assessments to ensure that quality services are provided (See Annex B). This includes:
  - » Undertaking a client flow mapping to assess bottlenecks and delays and inform the reorganization of services so that they are more efficient and effective;

- » Assessing the skills of health care providers, pharmacists, lab technicians and health extension workers to assess existing capacities and gaps for staff to deliver the package of integrated services and meet the needs of specific population groups, such as youth and key populations;
- » Assessing the equipment, commodities and supplies available to deliver the integrated package of services and identifying gaps;
- » Ensuring that the capacity of health care workers is sufficient to provide the package of integrated services, including on-the-job capacity-building opportunities within the in-service ITC.

#### 2.1.2.2 Regional and district level RMNCAH + N and Other Services Technical Working Groups

The RHMT/DHMT-level TWG, or a structure identified by the Reference Committee and National Level RMNCAH+N TWG, will oversee and provide technical guidance at regional and district level for the transition, implementation and sustenance of integrated service delivery.

Under the leadership of the designated senior RHMT official, the TWG will ensure the full participation of all health and non-health stakeholders in planning, budgeting, programme development, management monitoring, evaluation and reporting. To achieve this, the TWG should:

- Maintain an updated inventory of stakeholders or health service organizations.
- Promote the provision, highlight the benefits of and advocate for the provision of integrated client-centred services.
- Advocate for the buy-in of all stakeholders in the region/ district for the delivery of integrated services.
- Provide integration packages, guidelines and service standards.
- Monitor the provision of integrated services and undertake site visits to ensure that relevant standards of care and support are maintained.
- Ensure reporting, including on harmonized and integrated M&E tools and integration indicators.

#### 2.1.2.3 Regional focal points

The focal point for the provision of client-centred quality integrated services in the region/ district shall be designated by the RHMT/DHMT. Their roles include:

- Providing a link between the health region or district and the National Coordinator, and providing regular progress reports (weekly updates, monthly and quarterly reports) to the National Coordinator as required.
- Supporting the region/district in developing an action plan for transition to and provision of client-centred integrated health services.
- Serving as the link between facilities and the Regional/District Implementation Teams.
- Monitoring the roll-out and provision of client-centred integrated health services and providing systematic feedback to the RHMT/DHMT for remediation of challenges.
- Maintaining an updated inventory of stakeholders, particularly for non-health institutions, and ensuring their participation in meetings to plan, implement, evaluate and report.

#### 2.1.2.4 Cluster and facility managers

Cluster and facility managers guide the planning of services within their respective facilities, and are responsible for overseeing the process for transitioning to integrated service delivery for the communities they serve. The Cluster/ Facility Manager:

- Is the focal point for integration within the cluster or facility.

- Leads and supervises the process of integration, providing mentorship support and joint problem-solving.
- Manages implementation of the facility assessment to establish existing and required resources to ensure the provision of the package of services. This includes assessing:
  - » The client flow, to determine bottlenecks and opportunities to improve on the efficiency of delivery of integrated services;
  - » The skills of health care providers, pharmacists, lab technicians and health extension workers to deliver the package of integrated services;
  - » The availability of equipment, commodities and supplies and resource gaps and needs, to ensure that these are filled.
- Compiles, analyses and submits the needs assessment report to RHMT/DHMT and advocates for the necessary resources to ensure that the needs of the facility in terms of service integration are met.
- Supports, supervises and mentors health care workers, and conducts periodic audits to see whether they are on track (using or modifying the Supervisor's Checklist or template tool in Annex C).
- Identifies knowledge and skills gaps, and works with the RHMT/DHMT Lead to find ways to address them through on-the-job training, internal or external mentorship programmes or formal training programmes.
- Provides orientation and ensures the implementation of the Policy Guidelines.
- Maintains an inventory of key stakeholders and community structures working around the facility.
- Engages stakeholders and the community on the integration process, progress and addresses any bottlenecks that arise.

#### 2.1.2.5 Engaging and empowering people and communities

The involvement of community structures is central to the paradigm shift to provide client-centred integrated services, given that the community will ultimately be affected by and benefit from this provision. The Community-Based Health Strategy and guidelines launched under the MoHW mandate to engage communities, in line with the effort to revitalize PHC, provide detailed guidance on integration at this level of care.

Community structures that should be consulted and involved in the process of transitioning health services include: village health committees (VHCs); village development committees (VDCs); faith-based organizations (FBOs); community-based organizations (CBOs); community leaders; community volunteers; parent teacher associations (PTAs); and farmer organizations. These community stakeholders play an important role in the process of advancing the delivery of client-centred integrated services and the subsequent monitoring of service delivery. Their roles include sensitizing and mobilizing communities, ensuring that the service delivery approach benefits the community, engaging the facility manager on community concerns, bottlenecks and challenges, acting as an early warning mechanism for disease outbreaks, and assisting to develop and maintain structures.

FBOs and PTAs can be very active in the promotion of health and well-being in the community. FBOs can provide spiritual and psychosocial support, and act as a referral mechanism to link those in need of services to facilities. PTAs work in partnership with school health teams to ensure that services are provided to students or that students are linked to services.CBOs can have cadres of community volunteers who provide health information, education and communication (IEC), distribute basic commodities such as condoms, provide basic services such as HIV counselling and testing, and make referrals and link those in need of more advanced services to local facilities.

# 2.2 PREPARING THE HEALTH DISTRICT/ REGION TO TRANSITION TO INTEGRATED SERVICES

## THE PROCESS of transitioning to integrated services should be guided by a district implementation plan using a phased approach.

The district implementation plan enables districts to keep track of which facilities have been integrated, which are in the process of transitioning, and which are yet to transition. Where staff are rotated to facilities that have been integrated, they should be given orientation on the model being applied.

DHMT/RHMTs should prepare the facility manager, staff and stakeholders for integration. Resources such as staffing, capacity-building, commodities, equipment and supplies should be made available to support facilities in their transition to providing integrated services.

### Step 1: Brief the RHMT

The entire RHMT/DHMT should be briefed on the aims and objectives of integration, the benefits, roles, and models of integration to be applied, and the role of the region or district in assisting facilities to provide integrated services. Integration is a process, and will involve different members of the RHMT/DHMT:

- The Head of Preventative Services should lead and coordinate the process of integration jointly with the programme focal points. They should ensure that the updated guidelines for different services are available, as well as commodities and medicines.
- The Head of Curative Services and Nursing and Head of Corporate Services should ensure that staff rotation and allocation does not undermine integration efforts, and that sufficient resources, such as commodities, equipment and supplies, are made available to ensure that the full package of services can be delivered.
- RHMT management should prioritize the technical knowledge and skills gaps identified in the capacity development plan, to ensure that health care workers have the necessary skills to deliver integrated services sensitive to the needs of different populations.
- Facility managers and staff rotated to integrated facilities should be given orientation on the model and integrated package of services being provided.
- The Head of Corporate Services should provide the necessary administrative support for the facility to support the integration of services, including floor plans (as requested), supplies, furniture etc.
- Programme focal points should drive the process of integration, provide oversight, and undertake supervisory support visits to ensure the provision of quality integrated services.

## Step 2: Engage regional/ district stakeholders

One of the key characteristics of PHC is multisectorality. Not all determinants of health are covered within the health sector, so it is imperative that district stakeholders are engaged through existing structures, such as District Extension Teams, District Child Protection Committees, Business Botswana structures, District Development Committees and District Multisectoral AIDS Coordinating Committees (DMSACs), and others. These should be briefed on the health service reforms taking place, placing the integration agenda at the centre of actions to reinvigorate PHC and improve the health outcomes of communities, in line with aspirations to achieve the SDGs and UHC.

## Step 3: Map the types of facilities in the region/ district and their relevant models of integration

RHMT/DHMTs should map the number of facilities in the region or district and the models of integration that will be applied based on the nature of the facility and the population that it serves. RHMT/DHMTs should then determine the number of facilities that can be transitioned in a particular year, taking into consideration staff rotations that may require additional orientation for the facility manager and staff that are moving into the facility. The mapping should note that integration is a process, and the pace of integration will differ from one facility to the next based on their context. Table 3 below provides an example of how districts may wish to plan for the scale-up of provision of integrated services.

## Step 4: Develop a district/ regional implementation plan

Developing a district implementation plan is critical to guide the integration process. Districts should use a phased approach and keep track of which facilities have been integrated, which are in the process of transitioning to integrated service delivery, and which are yet to start the integration process. Health districts and regions should also ensure that where staff rotation takes place at facilities that have been integrated, new staff are given orientation on the integration model being applied.

When planning, RHMTs/DHMTs should ensure that resources are allocated to those facilities that are in the process of transitioning and provide orientation for the facility manager, staff and stakeholders to prepare for integration. Resources should be allocated that allow for the required staffing, capacity-building, commodities, equipment, furniture and supplies to ensure a seamless process of transitioning to providing the full package of services as appropriate per facility type.

**Table 3: Regional/district facility mapping**

| | Total NUMBER OF FACILITIES | Model of integration | YEAR 1 | YEAR 2 | YEAR 3 |
|---|---|---|---|---|---|
| **District hospitals** | 1 | Mall | | | 1 |
| **Clinics with maternity** | 7 | Supermarket | 2 | 3 | 2 |
| **Clinics without maternity** | 3 | Supermarket | 1 | 1 | 1 |
| **Comprehensive care centres** | 9 | Kiosk | 3 | 4 | 2 |
| **Health posts** | 18 | Kiosk | 6 | 6 | 6 |

The district or regional implementation plan guides the process of transitioning to integrated services. The plan should define the activities that will be undertaken, the time frame, responsible persons and budget. The activities include:

- Briefings and regular updates for senior management on the progress made, challenges, and whether the district is meeting its targets.
- Training of facility managers and staff that covers why integration is important, policies and guidelines, the models of integration, the needs of different population groups, the life cycle approach (continuum of care), the package of integrated services, and the commodities and supplies required to provide integrated services. The outcome of the training should be the facility action plan.
- Benchmarking visits enable each region or district to identify model sites for integration that can be used as a benchmark for others. Facilities should include a health post that applies the Kiosk Model, and a clinic with or without maternity as an example of the Supermarket Model. Learning visits should be undertaken to regions or districts with model sites, where such sites are not already available in a district.
- Facility self-assessments should be undertaken prior to integration to assess: i) staff capacity; ii) the availability of commodities, supplies and equipment; iii) community engagement; iv) opportunities; and v) challenges. (Annex B may be adapted for this purpose).
- Monitoring and evaluation is the responsibility of Regional M&E officers, who should collate and present data to facilities and management on progress in integration and the impact on service delivery.
- Supportive supervision from RHMT/DHMTs will be undertaken through regular supervisory visits to assess progress, mentor facility managers, provide feedback, identify and resolve problems and improve communication between the DHMT/RHMT and facility managers. Table 4 can be used as a tool to document these activities, and printed and posted for quick reference.

**Table 4: Regional/district implementation plan template**

| What | When | Where | Budgetary requirements (if any) | Lead person |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Step 5: Consult with health facility managers

Facility managers have overall responsibility for overseeing transition to an integrated facility. The DHMT/RHMT should engage with the managers of facilities earmarked for transition to integrated services. The engagement should outline:

- The roles and responsibilities of the facility manager to transition their facility.
- Relevant policies and guidelines.
- The meaning of people-centred and client-centred services.
- The appropriate model of integration and the reorganization of services to meet the needs of clients.
- The minimum package of services to be provided to clients based on their needs.
- The assessed staffing capacity and availability of equipment, commodities and supplies.
- The process for developing a plan to transition the facility to provide integrated person-centred health services.

Once facilities have been earmarked to transit and provide integrated services, it is important to engage the facility managers. This can be undertaken as part of a training programme to sensitize them on:

- Their roles and responsibilities in relation to transitioning their facility to an integrated facility.
- Relevant policies and guidelines that govern the provision of client-centred health integrated services.
- What it means to provide client-centred services and meet the needs of specific groups such as adolescents and youth, women and girls, men and boys, key populations and people living with HIV.
- The models of integration and the model appropriate to their facility, and how services should be restructured to meet the needs of clients.
- The minimum package of services to be provided based on the reasons for clients coming to the health facility.
- Assessing their facility to ensure that it has the staffing capacity, equipment, commodities and supplies to enable quality integrated people-centred health services.
- Developing a plan for the steps to transition and provision of integrated client-centred health services.

# 2.3 REORIENTING THE FACILITY TO PROVIDE PERSON-CENTRED INTEGRATED SERVICES

**THE PREVIOUS SECTION** examined the important role of RHMT/DHMTs in supporting facilities to transition to the provision of integrated health Services. This section provides guidance on the process of transitioning.

A self-assessment tool enables facilities to review and document progress on the delivery of integrated services, to identify strengths, weaknesses and challenges and can be adapted as necessary (Annex C). Supportive supervision is undertaken by the National TWG and the DHMT to ensure the provision of quality integrated services.

### Step 1: Orient facility staff

All staff should be given orientation by the facility manager and DHMT/RHMT on the integration of health services. Staff should identify a focal point or team leader who will support the facility manager to drive the transition process.

### Step 2: Develop a transition plan

The team designated to lead the integration process should engage all staff, including health care workers, pharmacists, M&E officers, health extension workers, lay counsellors, cleaners, drivers, gardeners and security guards.

A transition plan should be developed that outlines the transition process and time frame. (Table 4, p. 34 can be used in developing a transition plan).

### Step 3: Engage and empower stakeholders and community structures

The facility team leading the process of integration should map existing community stakeholders including CSOs supporting interventions in their facility or the surrounding community. Community structures include: *Kgosis*, community leaders, PTAs, traditional leaders, birth attendants and healers, VDCs and VHCs and the private sector.

A community consultation should be convened to explain the concept and the plan for transitioning to integrated services. The views of stakeholders and communities (both positive and negative) should be documented. Regular consultations should be organized during the process so that feedback can be provided and received on an ongoing basis, to help improve the integration process.

## Step 4: Undertake a facility situation assessment

The facility situation assessment describes: the way in which services are currently organized; the way in which services can be restructured taking into consideration the physical structure of the facility; the existing human resources, commodities, and supplies; and the vision for the facility transition (See Annex B).

### Mapping client flow

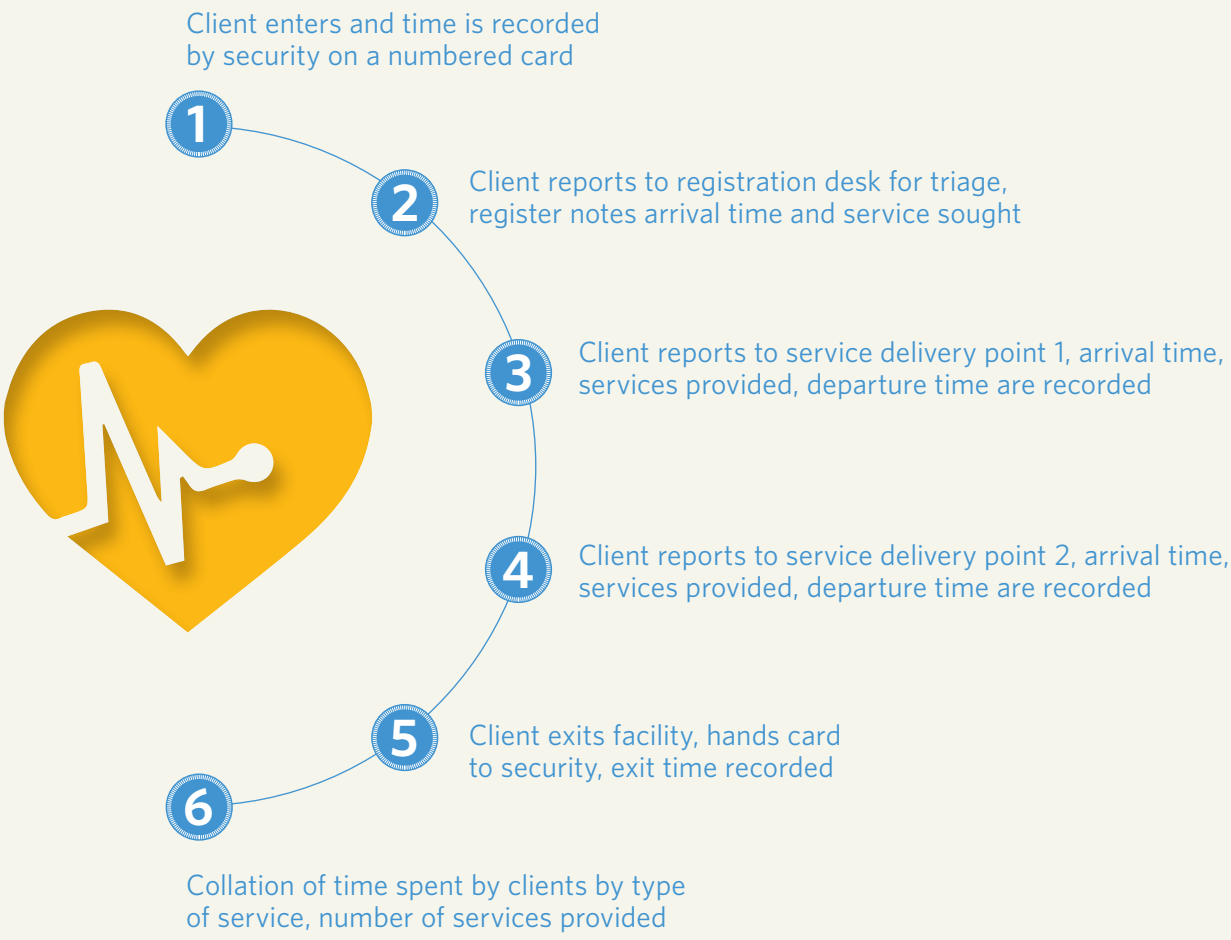
The assessment should map the current client flow and assess efficiencies. The client flow map can be determined by drawing a map of the facility, the various service delivery points, and the services being offered.

A time/motion study can help to determine how clients move from entry to exit, and how referrals take place, to identify efficiencies and bottlenecks. The diagram below depicts a simple client flow exercise.

The idea of a time/motion study is for external observers to capture data continuously on a system in order to identify bottlenecks and inefficiencies and improve system performance.

The client flow data can be analysed against the types of services sought, and the number of services provided, as well as the amount of time spent in the facility per service. Clients can be asked to rate the service and their experience. The client flow provides insights into how services can be reorganized to improve the experience of clients and the efficiency of service delivery.

**Figure 3: Client flow**



### Audit of available skills in the facility

The skills audit maps existing health care workers and community health care workers, their qualifications and training undertaken in relation to the package of integrated services and for particular population groups (adolescents and youth). The skills audit informs the development of a capacity-building plan for health care workers to address skills gaps that may exist.

### Inventory of commodities, supplies and equipment

An inventory should be undertaken of the commodities, supplies and equipment available in each room. This should be compared against the list of proposed services to be provided so that gaps can be identified, and plans made to ensure that commodities, supplies and equipment can be ordered in a timely manner (Annex B).

### Community-facility linkages

Draw a map of the community to show the areas currently covered by community health workers (CHWs). Create a list of the services provided and review the CHW qualifications, skills and expertise. Work with CHWs to map referral pathways, identify blockages and how to improve efficiency.

## Step 5: Prepare to deliver integrated services

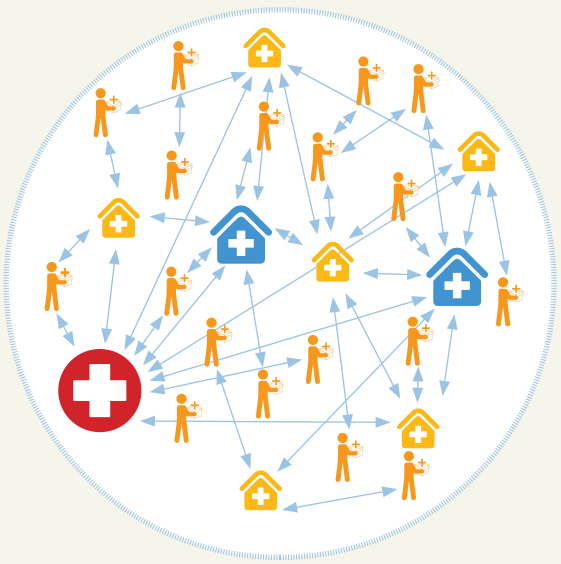
The model of integrated services to be provided will be informed by the nature of the facility, the size of the population it services, the services being provided, and the model of integration to be applied. Botswana applies four different models of service integration depending on nature of the facility.

1. Community Model: Services delivered by community health care workers and volunteers.
2. Kiosk Model: Health posts.
3. Supermarket Model: Clinics with maternity and without maternity.
4. Mall Model: Primary, district and referral hospitals.

These models do not exist in isolation, but form part of an overarching primary health care system that connects different levels of care, from community to hospitals, through referral pathways, as indicated in Figure 4 below.

**Figure 4: Functioning of primary health care system in a community**

Mapping of Primary Health Care facilities in a Fictitious Community in District X in Botswana




**CHWs** refer clients to health posts or clinics depending on the facility that they serve. The health post or clinic may also link patients with CHWs, for example to follow up on adherence counselling.

**Health posts** may refer clients to a clinic, with or without maternity, or to hospitals. Similarly, clinics and hospitals can refer clients down to their nearest health posts upon discharge.

**The health care system** can also link patients with other services including social services, government poverty alleviation schemes, YDF etc.

### Capacity-building for health care workers

The delivery of integrated people-centred services relies on health care workers who are motivated, skilled and operate in a supportive environment. The skills audit should be used to identify and address capacity gaps. Table 5 highlights various approaches to address capacity gaps.

Facility managers should ensure that all relevant national guidelines are on-site and easily accessible. All health care workers should be trained on the application of national guidelines, and refresher trainings should be organized as necessary to ensure the provision of quality services.

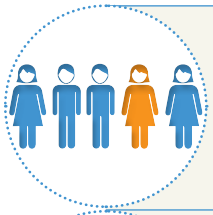
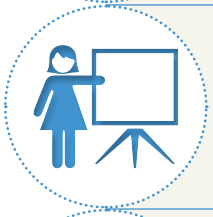
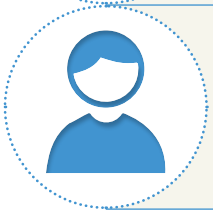
### Ordering commodities, supplies, furniture and equipment

Once there is agreement of how services are going to be integrated, it is important to ensure that commodities, supplies and equipment are available in each consultation room to enable health care workers to deliver the full package of services. Initially there will need to be careful monitoring of the provision of commodities and supplies to inform calculations of monthly requirements. Commodities and supplies should be ordered through the pharmacy supply chain system.

## Step 6: Innovate and use job-aids in integrated health services

Innovations are important to differentiate and customise services to the specific needs of communities and clients. One innovative practice incorporated into the integration model is the use of block-booking, which enables clients to schedule their visits to a clinic at times convenient for them. Block-bookings spread out the number of clients who come to a health facility over a day, avoiding congestion and reducing waiting time. As facilities introduce block-booking, provision also needs to be made for walk-in appointments, while efforts are made to sensitize the community to the advantages of the block-booking system, and how it works.

**Table 5: Training of Health Workers**

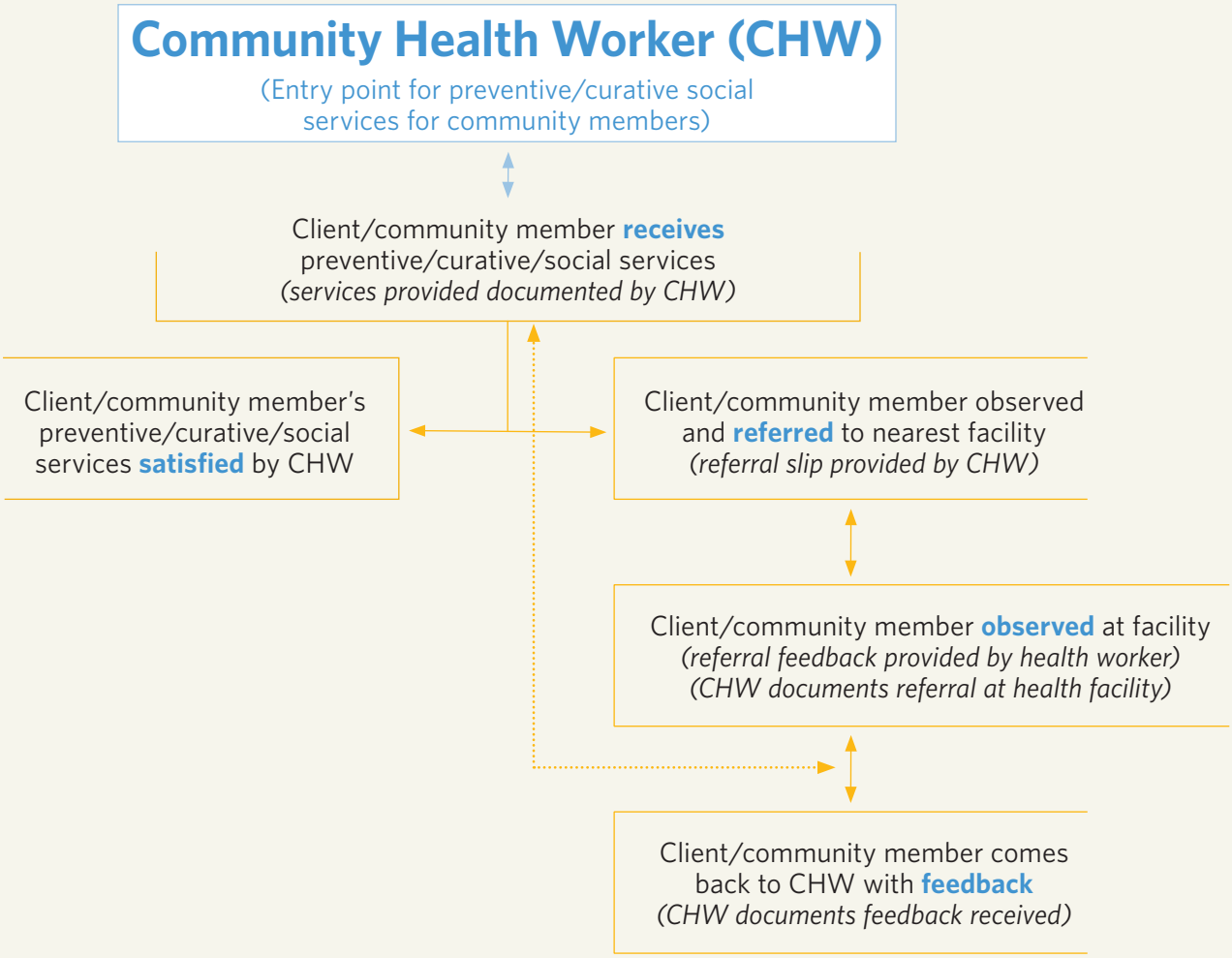
| | |
|---|---|
|  | **Training of Trainers:** Undertaken at the district level to build the capacity of a cadre of health care workers from health facilities, who in turn can train others to provide a particular service. |
|  | **In-service training:** Facilities identify capacity needs that are submitted to the DHMT/RHMT on an annual basis as part of a training plan. The DHMT Nurse Manager will identify those that are eligible. |
|  | **Mentorship/ supportive supervision:** Health care providers with specific skills mentor others on how to deliver the service. |

## Referral pathways

Key to ensuring that no opportunity is lost for clients to be offered and receive comprehensive integrated services, referral paths have to be clear and available for all.

It is important to map how referrals are done from one facility to another, and between service points. This will clearly outline the steps or actions to be taken or followed once a client has been assessed and determined to require attention from other providers, including outside of the immediate health facilities such as social services, guidance and counselling, teachers, police, safe accommodation etc. The diagrams below show two examples of referral pathways: Figure 5 for clients seen by CHWs in a community setting, and Figure 6 shows the referral pathway from the health facility.

**Figure 5: Referral pathways from a community-based setting to a facility**




**Source:** National Guideline for Implementation of Integrated Community-Based Health Services

**Figure 6: Referral pathway for a GBV client seen at a health facility setting**

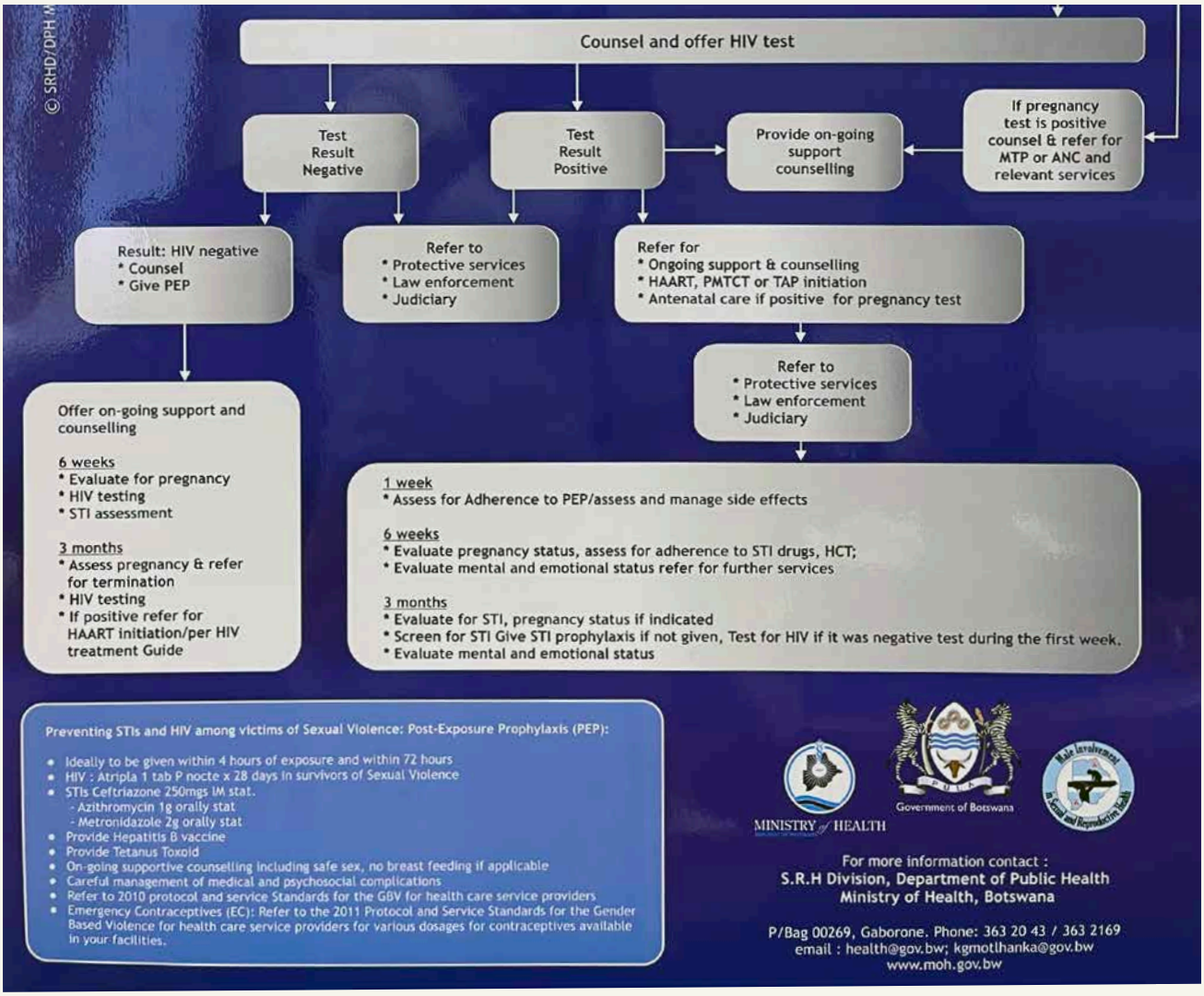



Figure 6 shows the flow for clients who have suffered GBV, and the different service points and services they can receive at health facilities under different scenarios (negative or positive HIV test result). It further reflects referrals made between health facilities and other GBV service providers, such as law enforcement (police) and protective services (social workers and domestic violence shelters).

## Integrated service models and packages

The models and packages differ slightly from those applied during the pilot phase, in order to align with health sector reforms and the strategic changes and direction of the health sector. The PHC approach is now the overarching approach to health care delivery, and the Community Model has been added to account for this shift. The menu of services that may be offered at each level of care has also been increased to account for the broader scope of integration guided by the policy. A total of four models or service packages have been established, to account for the different levels of care in the Botswana health care system. These are relevant for public, private and civil society settings.

### The Community Model

The Community-Based Health Strategy and guidelines launched as part of the MoHW mandate to engage communities, and in line with the effort to revitalize primary health care, provide detailed guidance on integrating services at this level of care.

The Community Model deals with integrating services within a community setting, which may include home visits, setting a mobile point of care within the safety of a community centre etc. These are services provided by trained health workers and volunteers, who spend a substantial part of their working time outside of the health facility, discharging their services at individual, family and community levels, and linking clients with facilities for continuity of care. These services are mostly provided by CHWs, often the first point of contact for clients.[29]

To support the health sector reforms, a detailed National Guidelines for Implementation of Integrated Community-Based Health Services has been developed, detailing and unpacking the minimum service package for this level, which aligns to the Integrated RMNCAH+N Strategy. The Guidelines provide guidance that aligns and associates services with responsible cadres, and provides guidance on a training curriculum and content.

Figure 7 shows the minimum service package that may be delivered by CHWs in a community setting, with examples of community-based service points and guidance on the different modalities through which a CHW may deliver the package.

**Figure 7: Community-based minimum services package**


[29] Botswana MoHW (2020) National Guideline for Implementation of Integrated Community Based Health Services in Botswana.

**Kiosk Model:**

Health Posts use the Kiosk Model, where a number of services are offered to clients in the same room by one health care provider. Table 6 below reflects a number of services that can be offered by providers at different points of care.

**Table 6: Kiosk Model: Health posts and small clinics**

| Point of care/ provider | Services |
|---|---|
| **Waiting area**<br>• Health Education Assistant<br>• Health Care Assistant<br>• Volunteers<br>• Nurses | » Health education<br>» Triage<br>» IEC<br>» Condom distribution<br>» HIV/TB/Malaria<br>» SGBV assessment<br>» EID |
| **Screening**<br>• Nurse<br>• Health Care Assistant<br>• Health Education Assistant | » Registration<br>» Vital signs<br>» Offer HIV /TB/STI/malaria testing<br>» Offer screening for reproductive cancer<br>» Condom promotion and distribution<br>» SGBV<br>» Offer screening for NCDs |
| **HIV Testing Services**<br>• Health Care Assistant<br>• Health Education Assistant | » Partner testing<br>» HIV counselling and testing<br>» STI screening<br>» Offer or refer for safe male circumcision (SMC)<br>» Screen/ offer for reproductive cancers<br>» Nutritional screening<br>» SGBV information and counselling<br>» Link to care<br>» EID |
| **Consultation Room**<br>• Nurse | » TB<br>» Malaria<br>» HIV testing<br>» Initiate on highly active antiretroviral therapy (HAART), monitoring and evaluation<br>» Link to care<br>» Hepatitis screening and referral<br>» Reproductive cancers<br>» STIs |

Table 6 (cont'd)

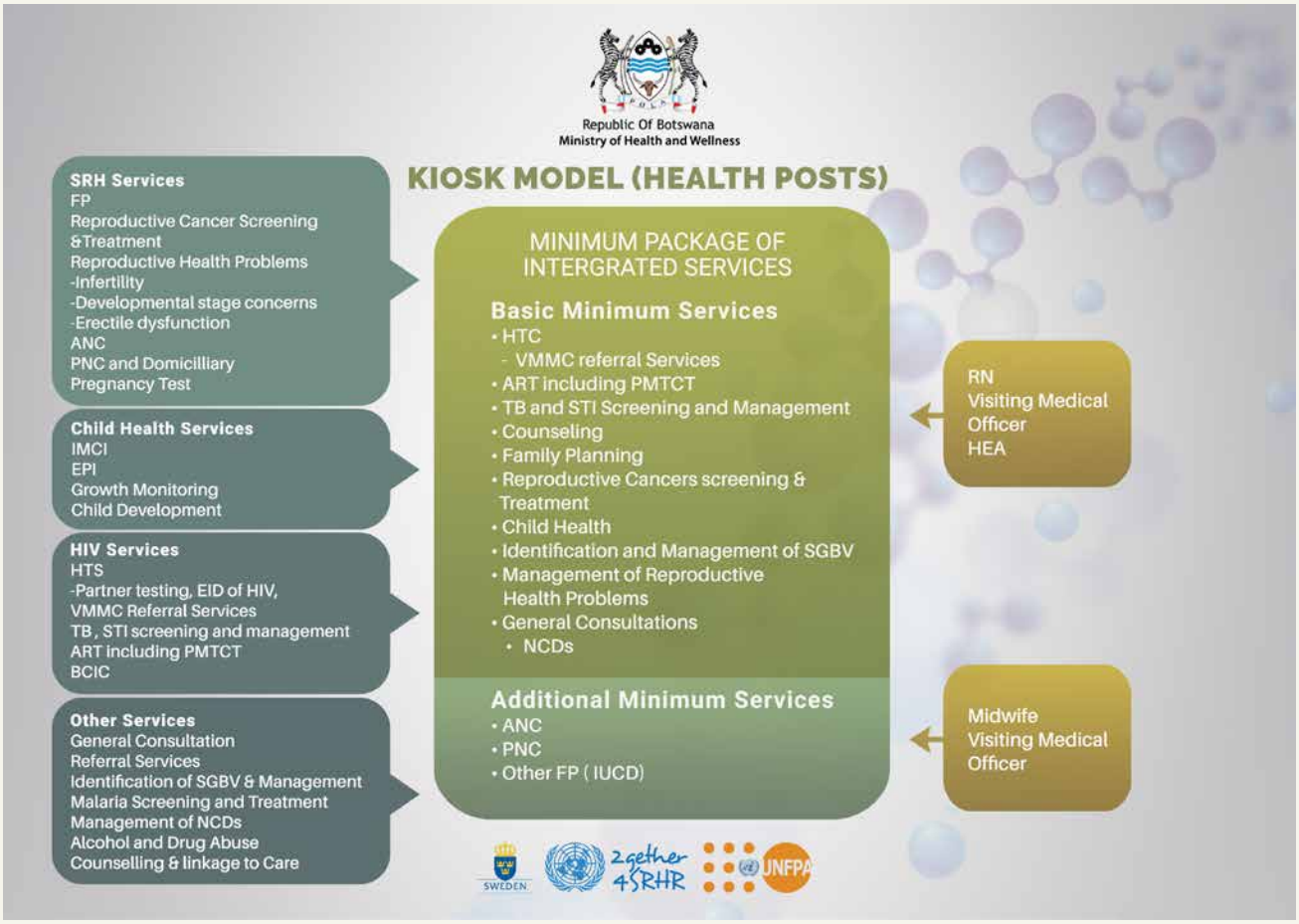
| Point of care/ provider | Services |
|---|---|
| *(cont'd)*<br>**Consultation Room**<br>• Nurse | » Offer or refer SMC<br>» SGBV information and counselling<br>» Curative services<br>» Family planning/ contraceptives<br>» Counselling on drug and alcohol use<br>» Pregnancy test for women of childbearing age<br>» Pre-conception counselling<br>» PEP<br>» Emergency contraceptives<br>» Child health<br>» Nutrition screening<br>» Male involvement<br>» NCDs<br>» IEC<br>» Condom promotion and distribution<br>» Mental health services |
| **Child Welfare clinic**<br>• Nurse<br>• Health Care Assistant | » Immunizations<br>» Nutrition assessment<br>» Infant feeding (infant and young child feeding, supplementary feeding, Vulnerable Groups Feeding Programme)<br>» Management of severe malnutrition<br>» Health education<br>» Family planning/contraceptives<br>» EID/ offering HTS<br>» Integrated Management of Childhood Illness<br>» Referrals<br>» Condom promotion and distribution<br>» Oral rehydration therapy and Zinc Sulphate<br>» Malaria<br>» Partner involvement<br>» NCDs |
| **Injection and wound dressing**<br>• Health Care Assistant<br>• Nurse | » Family planning/ STIs<br>» TB<br>» Condom distribution<br>» HTS<br>» SGBV information and counselling<br>» NCDs |

Table 6 (cont'd)

| Point of care/ provider | Services |
|---|---|
| **Dispensary**<br>• Pharmacy Technician<br>• Pharmacist | » Health education on drugs<br>» HTS<br>» Cancer screening<br>» Condom promotion and distribution<br>» TB screening<br>» IEC (family planning, alcohol and substance abuse, nutrition)<br>» NCDs |

Figure 8 shows the minimum service package for the Kiosk Model, which should also be delivered for mobile stops, which are outreach services that are designed to reach those in very remote areas and hard-to-reach populations.

**Figure 8: Kiosk Model services package**



### Adolescent and youth-friendly services

Adolescent and youth-friendly services are available in areas where there are a large number of young people. The model of integrated services at Adolescent and Youth-Friendly Service Centres is similar to the Kiosk Model, with clients receiving the full package of services from a health care provider in a single room. Table 7 highlights the types of services that can be provided.

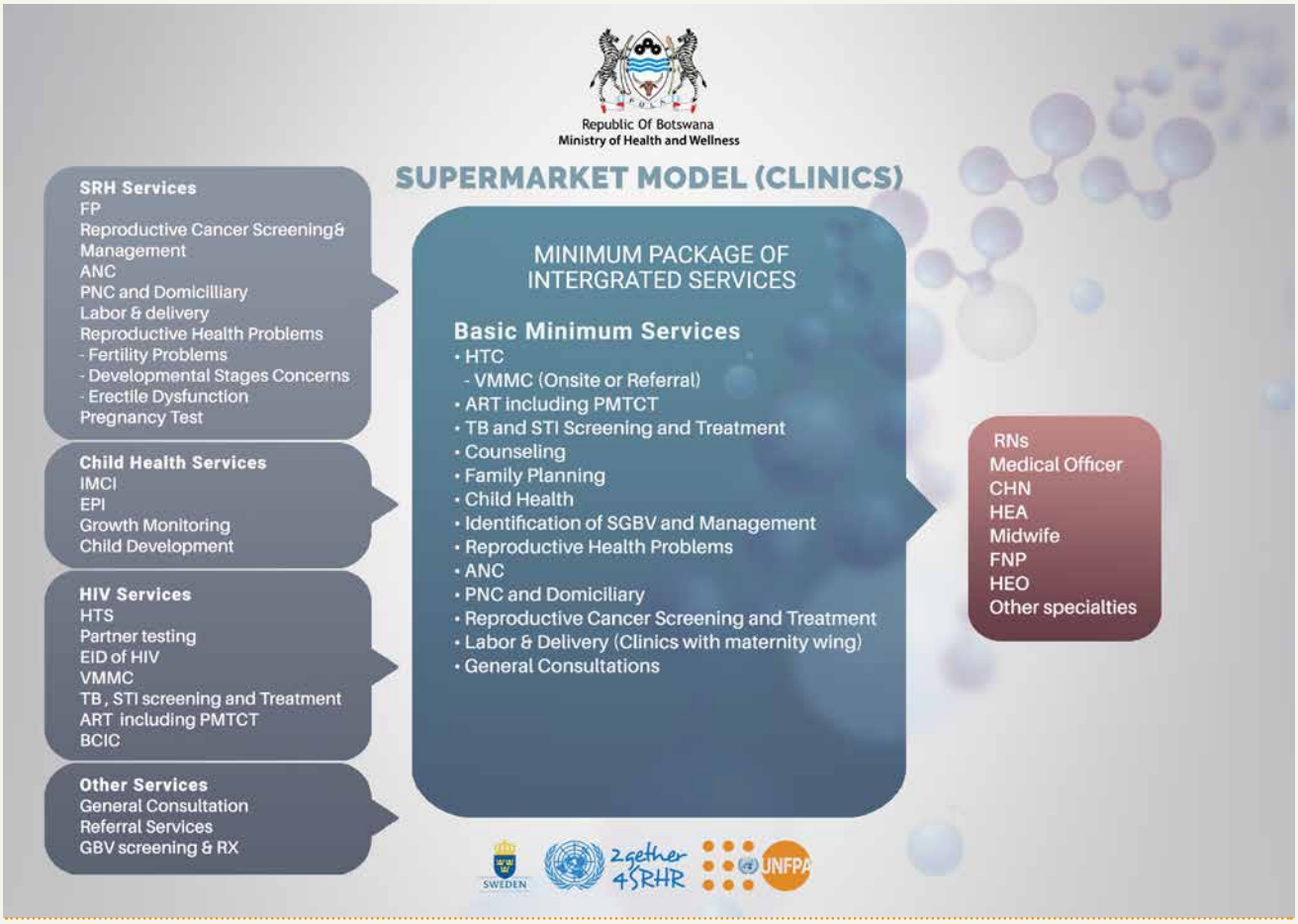
### Supermarket Model

The Supermarket Model is used in clinics, with and without maternity wards, which are bigger than a health post and have more rooms to use as entry points for different health care services. The skills mix of health care providers is more varied and numerous, which enables them to provide more services, as shown in Figure 9, p. 46.

**Table 7: Adolescent and youth-friendly services**

| Provider | Services |
|---|---|
| • Nurse<br>• Midwife<br>• Health Care Assistant | » Minor ailments/ consultation<br>» TB screening<br>» HCT<br>» Family planning services<br>» SGBV screening<br>» Nutrition screening<br>» Counselling on Post-Abortion Care (PAC)<br>» Emergency Contraceptive Pill (ECP)<br>» SMC offering and link to care<br>» Condom distribution<br>» General counselling<br>» STI screening<br>» Male involvement<br>» Cervical cancer screening<br>» Health education i.e. basic life skills<br>» IEC materials distribution<br>» Pregnancy testing<br>» Link to ART<br>» Antenatal and postnatal care<br>» Education and entertainment<br>» Mental health<br>» Referrals |

**Figure 9: Supermarket Model package of services**




Clients should be offered additional services beyond the reason for their consultation or outcome of their health screening. Once a consultation is completed, the client can be referred to other points of care for services offered. Table 8 reflects different scenarios or options of services that can be offered at the different points of care.

**Table 8: Differentiated services in the Supermarket Model**

| Point of care and provider | Package of Integrated Services to be Provided |
|---|---|
| **Screening Room**<br>• Nurse<br>• Health Care Assistant<br>*Client Flow:* Clients to be offered HTS and linked to HTS Service delivery point. If client does not want HTS, referred to consulting room for services. | » Registration<br>» Vital signs<br>» HTS (offer and refer to HCT counselling room),<br>» GBV information and counselling<br>» Nutrition<br>» TB screening<br>» Condom distribution<br>» IEC |

Table 8 (cont'd)

| Point of care and provider | Package of Integrated Services to be Provided |
|---|---|
| **Consultation Room**<br>• Doctor<br>• Nurse<br>• Family Nurse Practitioner (FNP) or midwife.<br>*Client Flow:* Client should be offered additional services beyond the reason for their consultation or outcomes of their health screening. Once consultation is finished client is referred to the dispensary or pharmacy for medication. | » History taking, physical assessment and management<br>» Assessment, monitoring and review vital signs to screen for NCDs and initiate on treatment where necessary<br>» Provision of treatment for STI and TB<br>» Provision of PEP for SGBV<br>» Provision of family planning<br>» Offer and/ or refer for SMC<br>» Referral for cancer screening<br>» HTS<br>» Pre-conception counselling and pregnancy testing<br>» Condom demonstration and distribution<br>» Link to care internal and external referral<br>» Initiate on HAART<br>» Mental health care<br>» IEC |
| **Wound Dressing**<br>• Nurse<br>• Health Care Assistant<br>*Client Flow:* Client should be offered additional services and linked to other service delivery points. For example, if a client wants HTS should be linked to HTS service delivery point or SRHR, or the consultation room if wanting family planning services. | » Wound assessment and dressing<br>» Monitor and evaluate dressing outcome<br>» Offer additional services for TB, STI, GBV, family planning, cancer and HTS and referral to appropriate services<br>» Condom distribution<br>» IEC materials |
| **Injection Room** (in some facilities injections and dressings are provided in the same room)<br>• Nurse<br>*Client Flow:* Client should be offered additional services TB, HTS, STI, GBV, family planning, and linked to appropriate service delivery point. For example, if a client wants HTS should be linked to HTS service delivery point or SRHR, or the consultation room if wanting family planning services. | » Check client medical card for correct injection and dosage<br>» Monitor and evaluate injection outcome<br>» Offer additional services for TB, STI, GBV, family planning, cancer and HTS and referral to appropriate services<br>» Condom distribution<br>» IEC materials |

Table 8 (cont'd)

| Point of care and provider | Package of Integrated Services to be Provided |
|---|---|
| **Child Welfare Services**<br>• Nurse<br>• Health Care Assistant<br>• Health Education Assistant<br>*Client Flow:* Caregiver should be offered additional services and linked to other service delivery points. For example, if a client wants HTS should be linked to HTS service delivery point or SRHR, or the consultation room if wanting family planning services. | » Assessment of child growth and development<br>» Feeding assessment and education<br>» Screen and give immunizations<br>» Provisions of supplements and minerals<br>» Screen the under-fives for HIV exposure, malaria and advise the caregiver to take the child for consultation for malaria (intra-facility referral)<br>» Offer caregiver health screening, HTS, TB and STI screening, malaria and family planning<br>» Condom distribution<br>» EID<br>» Male involvement – encouraging male partner support and involvement in the development and growth of the child<br>» Decam corners[30] |
| **Sexual and Reproductive Health Services**<br>• Nurse<br>• Doctor<br>*Client Flow:* Client offered additional services beyond the reason for their consultation or outcomes of their health screening. Once consultation is finished client is referred to the dispensary or pharmacy for medication. | » Contraceptive/ family planning services<br>» Pregnancy test<br>» Pre-conception counselling<br>» Confirmatory HIV test<br>» Partner HIV test<br>» Antenatal care (ANC), postnatal care (PNC), intrapartum, neonate and early infant care<br>» Male involvement<br>» GBV counselling<br>» Offer and refer for SMC<br>» HTS<br>» STI treatment<br>» Screening for reproductive cancers<br>» NCD<br>» Mental health<br>» Screening and treatment for TB<br>» Malaria<br>» Initiation of HAART<br>» Link to care<br>» IEC |

[30] Decam Corners are Oral Rehydration Therapy Corners set up to correct dehydration in the management of diarrhoeal illness in children.

Table 8 (cont'd)

| Point of care and provider | Package of Integrated Services to be Provided |
|---|---|
| **HIV Testing**<br>• Health Care Assistant<br>• Nurse<br>*Client Flow:* Client offered additional services beyond the reason for their consultation or outcomes of their health screening. Once consultation is finished client is referred to consultation by nurse. | » HIV counselling and testing<br>» Link to care<br>» Verbal screening |
| **Comprehensive Care Centres.** The services being delivered at these service delivery points are being expanded to include a full package of SRHR, HIV and SGBV services.<br>• Doctor<br>• FNP<br>• Nurse<br>• Midwife<br>*Client Flow:* Client offered additional services beyond the reason for their consultation or outcomes of their health screening. Once consultation is finished client is referred to the dispensary or pharmacy for medication. | » Contraceptive/family planning services<br>» Pregnancy test<br>» Pre-conception counselling<br>» Confirmatory HIV test<br>» Partner HIV test<br>» ANC, PNC, intrapartum, neonate and early infant care<br>» Male involvement<br>» GBV prevention and management<br>» HTS<br>» STI treatment<br>» Screening for reproductive cancers<br>» NCD screening<br>» Screening and treatment for TB<br>» Mental health care<br>» Malaria<br>» Initiation on HAART<br>» Link to care<br>» IEC |

### Mall Model

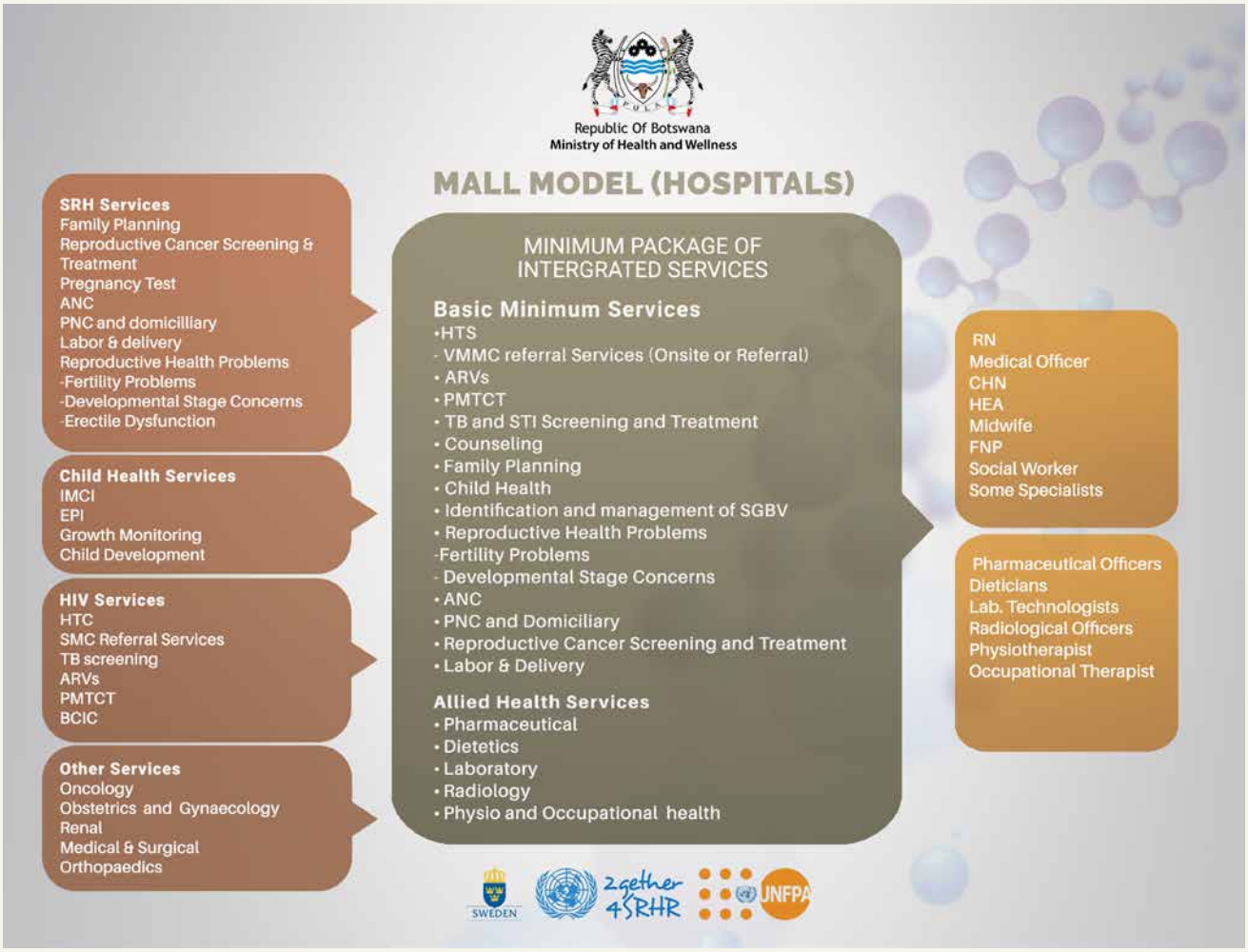
This model is applicable to hospitals, whether primary, general or referral. Here, services are internally disaggregated, and referrals are expected and routine to support service integration. Specialized services are available in these facilities but more compartmentalized compared to other facilities such as the health post and clinics. The infrastructure of these facilities favours this kind of arrangement.

Given that service providers are trained to offer comprehensive services, integration can occur, but the challenge will be the walking distances for users within the hospital and joining different queues in order to access services. While service providers are trained to provide comprehensive services, very few of the prescribed services such as family planning, maternal and child health and STI services are linked and provided at the same location.

Given the structure and role of these hospitals, major structural changes are not envisaged for them to operate integrated services, as all referral hospitals are completely equipped for all services. The main change for service providers will be that they no longer use their discretion, but will follow prescribed integration guidelines to deliver proactive, preventive and curative services to all.

The middle column of Figure 10, below, shows the services that constitute the minimum health services package to be offered in the Mall Model, whilst the column to the left unpacks and lists the specific services provided under SRH, Child health, HIV and others. In the far right is a list of health care providers who would at the minimum be required for the minimum package to be delivered.

**Figure 10: Mall Model package of services**



### 2.3.7 Step 7: Coordinate across sectors

Facilities should map the non-health services that are being provided by other stakeholders in the community and establish close linkages with partners so as to facilitate cross-referral between the health facility and its stakeholders. Stakeholders could include (but not limited to):

- Social workers, psychologists, psychiatrists and psychiatric nurses in the community who can provide psychosocial support services to clients in need.
- Police services for GBV or child sexual abuse survivors. It may be useful to work with the local police station to identify a police officer that can be the point of contact for all cases relating to GBV.
- Teachers and other educators in surrounding schools that can be a point of referral for adolescents and youth to access SRHR and counselling services, or that can invite the clinic to give health talks at school.
- Traditional healers and birth attendants can be allies in identifying cases in need of medical intervention and refer their clients to health facilities for advanced care.
- CSOs and CBOs, including groups working with men and boys, out-of-school adolescents and youth, and the lesbian, gay, bisexual, transgender, queer and intersex community. The facility should establish close linkages with these partners and refer clients in need for services to them. Similarly, the facility should encourage the partners to refer clients in need of services to the facility.

### 2.3.8 Step 8: Data collection and reporting

Monitoring is intended to provide data that enables stakeholders to measure the extent to which clients are receiving integrated services that are: designed to meet their life cycle needs and social preferences; coordinated across the continuum of care; and comprehensive, safe, effective, timely, efficient and acceptable. Monitoring data also helps to inform decision-making. District M&E officers should be part of the district integration teams so that they can support facilities in monitoring the provision of integrated services.

**Table 9: M&E bottom-up data flow**

| |
|---|
| RHMT/DHMT M&E Officer collates and compiles the data and presents to national level by the 15th of every month. |
| RHMT/DHMT M&E Officer collates and compiles the data and presents to Regional/ District Performance Improvement Committee. |
| Facility reports compiled and submitted to the RHMT/ DHMT by 5th of each month. |

# 2.4 MONITORING AND EVALUATION

**IMPLEMENTATION** needs to be monitored alongside the M&E of specific health programmes and interventions in order for the transition to an integrated service delivery to be successful.

M&E will assist in the early identification of challenges and gaps at all levels of the health care system, and provide a timely opportunity for remedial action. A monitoring tool has been developed to assist those responsible for managing integration at each level of care, and strengthen their accountability. Integration-specific indicators have also been developed to facilitate tracking and reporting nationally, regionally and globally (Annex D). This tool can be further refined to respond to periodical changes and developments in M&E applications.

In recognition of the importance the Government attaches to the vital role of good data in the realization of SDGs targets and UHC, and in line with the global call for a more aligned and harmonized approach to improving the quality of data and statistics, MoHW is leading the strengthening of the Health Management Information and M&E Systems through a collaborative approach.[31] The health sector has therefore developed the 'Botswana Health Data Collaborative Road Map', which provides a platform for development partners, technical experts, implementers, CSOs, private sector and policymakers to work together for an improved health information system and M&E. The road map emphasizes alignment and harmonization as key to a strengthened District Health Information Software (DHIS) and M&E system. Most importantly, the harmonization of indicators is ongoing to facilitate alignment, digitalization and sharing of data across the health sector (in public, private and CSO settings). Programmes and operational services will identify key core indicators that need to be routinely captured and tracked, for inclusion in the Electronic Medical Records and DHIS2, with the understanding that other data will be collected through surveys.

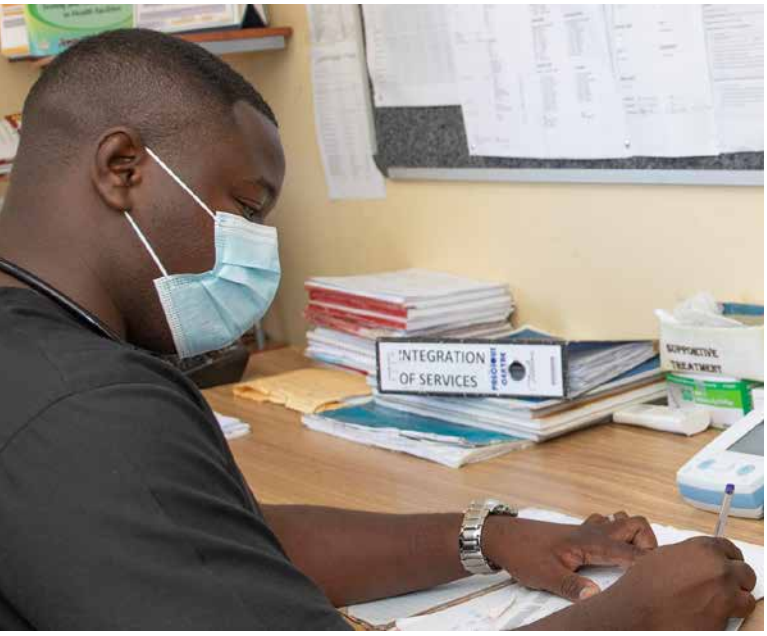
The road map identifies a number of key strategic actions under its pillars, including:

- Establishing an eHealth Platform including a data warehouse and eHealth Services.
- Establishing a single Integrated DHIS2 Platform as a default reporting system with interface capability.
- Establishing a home grown Electronic Medical Records system for capturing patient level data.

[31] Botswana MoHW (2020) Botswana Health Data Collaborative Road Map (2020-2025)- Towards a harmonized health Information and Monitoring & Evaluation System in Botswana.

- Addressing equipment and internet needs.
- Enhancing the use of International Classification of Disease (ICD) certification and coding.
- Fully aligning all health sector stakeholders within a single country framework for a Health Information System.

For integration to be adequately put into effect, including monitoring, evaluation and reporting, it will be critical to develop supportive digital systems. These will lessen the burden currently imposed by multiple registers and tally sheets, whilst improving the quality of data and facilitating data use for programme and policy decision-making. This clearly indicates the need for information technology (IT) equipment to support the use of a digitalized system. A system for protecting the equipment, including tracking, is also being explored, as the health sector responds to the e-Health Strategy, and the high IT equipment requirements for the management of health information and strengthening the health care system. Human resource capacity-building in the use of IT equipment has been identified as a priority.

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Programme managers should work with the Department of M&E to identify key variables to include in the harmonized and integrated digital health system management platform that is being developed. Other variables reported in regional and global platforms should be harmonized with local ones and included in the health system Management Information System.

The SADC SRH Strategy, for example, seeks universal access to integrated, comprehensive services, particularly for young people, women and key and other vulnerable populations, including in humanitarian settings (SDGs 3.7 and 5.6). The score card is a high-level strategic tool to track political progress on implementation of the SADC SRHR Strategy 2019– 2030 across the region, against core indicators such as: the proportion of the population accessing integrated SRH services (total population) and health worker density.[32] National indicators are being reviewed to align with regional indicators and will be harmonized and reduced for inclusion in the integrated, harmonized M&E system.

In addition to systems-related issues, collected data has to be adequately disaggregated to inform targeted programming and interventions, and sufficiently comprehensive to lend itself to reporting, especially of progress on the implementation of strategies and actions that respond to the goals to which Botswana has committed.

[32] SADC (2019) SRHR Strategy 2019 – 2013 Score Card.

# 2.5 CRITICAL ENABLERS

1. Strengthen regional structures, including the support system.
2. Train health personnel on their enhanced job responsibilities, including task-sharing (which is an important determinant of the success of integrated health service delivery) and block-booking.
3. Ensure adequate staffing and retention. Addressing push factors such as understaffing and implementing retention efforts will alleviate health human resources-related impediments.
4. Ensure strong leadership and governance (supervision, leader-driven transition, change management).
5. Secure financing (rational allocative decisions and efficiencies).
6. Promote digitalization of the DHIS and M&E.
7. Provide different funding models for CSOs so that they can comprehensively integrate.
8. Develop and disseminate a referral system which facilitates linking clients to other service providers, does not expose them to repeating their stories.
9. Ensure availability of medicines and commodities.
10. Facilitate community participation.

# SECTION 3

# CONCLUSIONS

## INTEGRATED SERVICE DELIVERY requires a high level of political commitment, communication and collaboration for ownership and resource mobilization.

In the current public health scenario, where health system strengthening is playing a pivotal role in improvements in access to, and the coverage, quality and efficiency of services, integrated service delivery has become increasingly important and occupies centre stage in the reinvigoration of PHC in Botswana. This recognises the key role of community health systems and the need to strengthen them. In order for integration to be successfully institutionalized at all levels of the health care system, it should encompass all aspects of the health system: human resources, services, infrastructure and information systems. The critical enablers identified by key stakeholders point to this. The involvement of service users in the planning and operation of integration is essential for acceptance and ownership. However, there is limited evidence of the best strategies for integration, and these vary depending on culture, geography, economy and policy environment. It is worth noting that integration is a process and will occur over time, with the requisite accountability at all levels. Change is leader-driven and managed.

Integration is not an end in itself, but a means to an end. It is one of the many ways of improving and sustaining the health care delivery system. But it is a definite need today, especially for underdeveloped and developing countries.[33]

[33] WHO (2008) Integrated health services - what and why? Technical Brief No.1: http://www.who.int/healthsystems/service_delivery_techbrief1. pdf

# REFERENCES


1. Government of Botswana, MoHW (2018) Botswana Multi-Sectoral Strategy for Prevention and Control of Non-Communicable Diseases (2018-2023).
2. https://www.who.int/news-room/fact-sheets/detail/primary-health-care
3. https://www.gov.bw/ministries/ministry-health-and-wellness
4. Government of Botswana, MoHW Strategic Plan (2017-2023).
5. WHO (2008) Integrated Health Services, When and Why, Technical Brief No.1.
6. WHO (2008) Operations Manual for Staff for delivery of HIV prevention, care and treatment at Primary Health Care Centres -Service integration, linkages and triage.
7. WHO (2008) Global Recommendations and Task Shifting Guidelines.
8. https://www.who.int/health_financing/universal_coverage_definition/en/
9. Mills, A., S. Bennett and S Russel (2001) Health Sector Reform and the Role of Government
10. WHO (2016) Community-based Health Services: a vital part of Universal Health Coverage Universal Health Coverage discussion paper 1.
11. https://www.who.int/news-room/fact-sheets/detail/primary-health-care
12. https://www.who.int/news-room/fact-sheets/detail/primary-health-care
13. Government of Botswana (2016) Vision 2036: Achieving prosperity for all.
14. https://www.who.int/teams/integrated-health-services
15. Government of Botswana, Ministry of Finance and Economic Development Presidential Task Team (2016) VISION 2036 – Achieving Prosperity for All.
16. Government of Botswana, MoHW (2010) The Essential Health Service Package for Botswana.
17. Botswana National AIDS and Health Promotion Agency (2018) Third National Strategic Framework on HIV and AIDS: Enhancing Efficiencies Through an Integrated Approach (2018-2023).
18. Government of Botswana, MoHW. (2011) National Health Policy: Towards A Healthier Botswana.
19. Government of Botswana, MoHW (2010) Integrated Health Service Plan: A Strategy for Changing the Health Sector For Healthy Botswana 2010-2020.
20. WHO (2016) Causes of Death in Botswana.
21. Botswana National AIDS and Health Promotion Agency (2018) Botswana Multi-Sectoral Strategy for the Prevention and Control of Non-Communicable Diseases 2018-2023.
22. WHO (2019) Analysis and Use Of Health Facility Data - Guidance for RMNCAH programme managers.
23. Maputo Plan of Action (2016-2030).
24. WHO (2015) Every Woman Every Child: Global strategy for women's, children's and adolescents' health 2016–2030.
25. Government of Botswana (2017) Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan (2017-2021).
26. Avalos, A; P. Heston and K. Jefferis (2016) Botswana Investment Case Study: Investment towards effective HIV prevention, health systems strengthening and the end of AIDS. Government of Botswana.
27. Government of Botswana (2016) Client satisfaction survey in pilot health facilities implementing SRHR/HIV Linkages Project.
28. Government of Botswana, MoHW. Integration of Sexual and Reproductive Health Rights and HIV services in Botswana.
29. Government of Botswana, UNFPA and UNAIDS (2016) Evaluation of the Linkages Project.
30. Government of Botswana, Ministry of Finance and Economic Development (2017) National Development Plan 11(2017-2023).
31. WHO (2007) The World Health Organization "Building Blocks" framework
32. WHO (2008) Integrated health services - what and why? Technical Brief No.1. http://www.who.int/healthsystems/service_delivery_techbrief1. pdf
33. African Union (2009) CARMMA 2009-2019.
34. African Union (2003) Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.
35. https://au.int/en/pressreleases/20191123/
36. https://allafrica.com/stories/202002060150.html
37. Government of Botswana, MoHW (2016) Client Satisfaction Survey Conducted in Pilot Health Facilities Implementing SRHR / HIV Linkages Project.

# ANNEXES

## **Annex A:** Terms of Reference for RMNCAH+N and Other Services Reference Committee

### MINISTRY OF HEALTH AND WELLNESS

The national RMNCAH+N and Other Services Reference Committee guides and coordinates the process of the delivery of client-centred integrated services. The Reference Committee, which is a high-level structure, is chaired by the Permanent Secretary and comprises representatives from:

- Managers of different line functions in MoHW and NAHPA.
- The leadership of key CSO networks or national CSOs that have a role to play in integration service delivery and M&E.
- Development partners such as relevant United Nations agencies and bilateral partners such as the European Union
- Relevant non-health institutions such as the Botswana Network on Ethics, Law and HIV/AIDS, Botswana Council of Non-Governmental Organizations and SADC.

This may from time to time be updated.

The work of the Reference Committee is facilitated by the National Coordinators (ISD and ITC), with support from the TWG. The work of the Committee includes to:

- Oversee the development, implementation and M&E of the national effort to provide client-centred integrated health care services.
- Provide direction on the alignment of strategic integrated programme interventions with national and health policies, including Vision 2036, NDP 11, the revised National Health Policy and the MoHW Strategic Plan 2017-2023.
- Provide direction on the implementation of responses and services that are cost-efficient, effective and responsive to the attainment of the SDGs and other national health goals, including those of health sector reform.
- Ensure coordinated budgeting, planning, implementation and M&E of prioritized integration interventions.
- Guide allocative decisions to ensure that health reforms and prioritized strategies are adequately resourced.
- Monitor the scale-up of integrated service delivery, and contribute to the development and review of policies, guidelines and strategies.
- Coordinate interagency support for integrated service delivery, including from development partners, the United Nations family, international NGOs etc., to facilitate harmonized implementation and avoid duplication.
- Coordinate, harmonize and assist interagency support to the national scale-up plan to providers of client-centred integrated services in Botswana.
- Support the development of a framework and plan for M&E and oversee the integration M&E efforts including the harmonization of data collection and reporting tools, as well as electronic platforms.
- Consider and approve integration scale-up plans and reports as submitted by the TWG.
- Ensure human resource availability and development to support the provision of integrated services. Advocate for and support human resource development to improve the quality of services at all levels.

- Ensure that necessary equipment, supplies, and commodities are made available to support the provision of integrated services.
- Facilitate the representation of Botswana in regional and international fora to highlight progress made, lessons learned and share experiences on the delivery of client-centred integrated services.

# **Annex B:** Facility Readiness Assessment Tool

| Point of service/ providers | Services to be provided | Services available - Tick as applicable | Resources (equipment, human resources, supplies) that need to be mobilized to provide the services (if not available) | | | |
|---|---|---|---|---|---|---|
| | | | Human resources | Equipment | Supplies and commodities | IEC + job-aids |
| **Waiting area:**<br>• Health Education Assistant<br>• Health Care Assistant<br>• Volunteer<br>• Nurse | » Health education | | | | | |
| | » Triage | | | | | |
| | » IEC materials | | | | | |
| | » Condom distribution | | | | | |
| | » Offering HIV/ TB/ malaria screening | | | | | |
| | » SGBV assessment | | | | | |
| | » EID | | | | | |
| **Screening**<br>• Nurse<br>• Health Care Assistant<br>• Health Education Assistant | | | | | | |
| | » Registration | | | | | |
| | » Vital signs | | | | | |
| | » Offer HTS/ TB/ STI/ malaria screening | | | | | |
| | » Offer screening for reproductive cancer | | | | | |
| | » Condom promotion and distribution | | | | | |
| | » SGBV information and counselling | | | | | |
| | » Screening for NCDs | | | | | |

◀ Annex B (cont'd)

| Point of service/ providers | Services to be provided | Services available - Tick as applicable | Resources (equipment, human resources, supplies) that need to be mobilized to provide the services (if not available) | | | |
|---|---|---|---|---|---|---|
| | | | Human resources | Equipment | Supplies and commodities | IEC + job-aids |
| **HIV Testing Services**<br>• Health Care Assistant<br>• Health Education Assistant | | | | | | |
| | » Partner testing | | | | | |
| | » HIV counselling and testing | | | | | |
| | » STI screening | | | | | |
| | » Offer or refer for SMC | | | | | |
| | » Screen/ offer for reproductive cancers | | | | | |
| | » Nutritional screening | | | | | |
| | » SGBV information and counselling | | | | | |
| | » Link to care | | | | | |
| | » EID | | | | | |
| **Consultation Room**<br>• Professional Nurse | » TB | | | | | |
| | » Malaria | | | | | |
| | » HIV Testing | | | | | |
| | » Initiate on HAART, monitoring and evaluation | | | | | |
| | » Link to care | | | | | |
| | » Hepatitis screening and referral | | | | | |
| | » Reproductive cancers | | | | | |
| | » STI | | | | | |
| | » SMC (offer or refer) | | | | | |
| | » SGBV information and counselling | | | | | |
| | » Curative services | | | | | |
| | » Family Planning/ contraceptives | | | | | |

| Point of service/ providers | Services to be provided | Services available - Tick as applicable | Resources (equipment, human resources, supplies) that need to be mobilized to provide the services (if not available) | | | |
|---|---|---|---|---|---|---|
| | | | Human resources | Equipment | Supplies and commodities | IEC + job-aids |
| *(cont'd)*<br>**Consultation Room**<br>• Professional Nurse | » Counselling on drug and alcohol use | | | | | |
| | » Pregnancy test for women of child-bearing age | | | | | |
| | » Pre-conception counselling | | | | | |
| | » PEP | | | | | |
| | » Emergency contraceptives | | | | | |
| | » Child health | | | | | |
| | » Nutrition screening | | | | | |
| | » Male involvement | | | | | |
| | » NCDs | | | | | |
| | » IEC | | | | | |
| | » Condom promotion and distribution | | | | | |
| **Child Welfare clinic**<br>• Professional Nurse<br>• Health Care Assistant | » Immunizations | | | | | |
| | » Nutrition assessment | | | | | |
| | » Infant feeding (infant and young child feeding, supplementary feeding, vulnerable groups feeding programme) | | | | | |
| | » Management of severe malnutrition | | | | | |
| | » Health education | | | | | |
| | » Family planning/ contraceptives | | | | | |
| | » EID/ offering HTS | | | | | |
| | » Integrated management of childhood illness | | | | | |

| Point of service/ providers | Services to be provided | Services available - Tick as applicable | Resources (equipment, human resources, supplies) that need to be mobilized to provide the services (if not available) | | | |
|---|---|---|---|---|---|---|
| | | | Human resources | Equipment | Supplies and commodities | IEC + job-aids |
| *(cont'd)*<br>**Child Welfare clinic**<br>• Professional Nurse<br>• Health Care Assistant | » Referrals | | | | | |
| | » Condom promotion and distribution | | | | | |
| | » Oral rehydration therapy and zinc | | | | | |
| | » Malaria | | | | | |
| | » Partner involvement | | | | | |
| | » NCDs | | | | | |
| **Injection and wound dressing**<br>» Health Care Assistant<br>» Professional Nurse | » family planning/ STI/ TB | | | | | |
| | » Condom distribution | | | | | |
| | » HTS | | | | | |
| | » SGBV | | | | | |
| | » NCDs | | | | | |
| **Dispensary** | » Health education for drugs | | | | | |
| | » HTS | | | | | |
| | » Cancer screening | | | | | |
| | » Condom promotion and distribution | | | | | |
| | » TB screening | | | | | |
| | » IEC (family planning, alcohol and substance abuse, nutrition) | | | | | |
| | » NCDs | | | | | |

# **Annex C:** Facility Self-Assessment Tool – Integrated Services

| DRAFT FACILITY SELF ASSESMENT TOOL - INTEGRATED SERVICES | | | | | | | |
|---|---|---|---|---|---|---|---|
| Site Name:_____ | | | | Name of Supervisor_____ | | | |
| Date_____ | | | | Respondent_____ | | | |
| **ACTIVITY** | **RATING** | | | **VERIFICATION** | **COMMENT** | | |
| | **2** | **1** | **0** | | | | |
| **COMMUNITY** | | | | | | | |
| Officer trained on integration | | | | 3 DAYS TRAINING | | 2 | meets standard |
| Establish availability of reporting forms and registers | | | | Completeness, correctness, confidentiality | | 1 | Average |
| Work plan | | | | 1 | | 0 | Below Average |
| Review records if all patients on ART return to clinic for follow-up within one month of starting ART | | | | | | | |
| Home visits (max 10) | | | | 2 - 3 houses per day | | | |
| Consultative meeting | | | | Quarterly | | | |
| Health talks | | | | 5 per week | | | |
| IEC materials | | | | Available/ issued | | | |
| Guidelines for integration | | | | Available | | | |
| Linked to care | | | | Number | | | |
| Demonstrations of condom use | | | | 2 per week | | | |
| School visits | | | | 2 per term | | | |
| Provider-initiated care | | | | Number initiated and number accepted | | | |
| Commodities | | | | Available | | | |
| **KIOSK** | | | | | | | |
| | | | | | | 2 | meets standard |
| Capacity-building | | | | 5 days | | 1 | Average |

Annex C (cont'd)

| ACTIVITY | RATING 2 | 1 | 0 | VERIFICATION | COMMENT | | |
|---|---|---|---|---|---|---|---|
| Plan of action | | | | 1 | | 0 | Below Average |
| Home visits | | | | 10 weekly visits | | | |
| Consultative meetings | | | | 4 | | | |
| Health talks | | | | 5 | | | |
| Registers | | | | Completeness, correctness, confidentiality | | | |
| IEC materials | | | | For various programmes | | | |
| Links to care | | | | Number linked to care | | | |
| Guidelines for integration | | | | Available | | | |
| Follow Up care | | | | Number of visits | | | |
| Demonstration models | | | | 2 per consultation room | | | |
| Provider-initiated services | | | | Number | | | |
| Number of provider-initiated services taken | | | | Number | | | |
| **SUPERMARKET** | | | | | | | |
| Capacity-building | | | | 5 days | | 2 | meets standard |
| Plan of action | | | | 1 | | 1 | Average |
| Home visits | | | | 10 weekly visits | | 0 | Below Average |
| Consultative meetings | | | | 4 | | | |
| Health talks | | | | 5 | | | |
| Registers | | | | Completeness, correctness, confidentiality | | | |
| IEC materials | | | | For various programmes | | | |
| Links to care | | | | Number linked to care | | | |

| ACTIVITY | RATING | | | VERIFICATION | COMMENT | | |
|---|---|---|---|---|---|---|---|
| | 2 | 1 | 0 | | | | |
| Guidelines for Integration | | | | Available | | | |
| Follow-up care | | | | Number of visits | | | |
| Demonstration models | | | | 2 per consultation room | | | |
| Provider-initiated services | | | | Number | | | |
| Number of provider-initiated services taken | | | | Number | | | |
| Entry point Out-patient Department (Offered family planning, HTS, TB screening, HIV prevention) | | | | | | | |
| Client comes for STIs (family planning, HTS, fertility counselling, HIV prevention and cancer screening) | | | | | | | |
| Client comes for TB Care (family planning, HTS, HIV prevention, nutrition counselling, prevention and management) | | | | | | | |
| Client comes for SGBV (post-abortion care, HTS, psychological counselling, links to legal services) | | | | | | | |
| PEP, HIV prevention and commodities, TB screening, STI screening, pregnancy testing, emergency contraceptives | | | | | | | |
| Client comes for family planning (STI screening, HTS, TB screening, cancer screening, SGBV, HIV prevention, social behaviour change) | | | | | | | |
| Client comes for HTS (family planning and commodities, SGBV, PEP, TB screening, VMMC, abortion education, STI screening, HIV prevention, link to care, SBGV) | | | | | | | |
| Client comes for ANC (information on alcohol and drugs use, malaria screening, HTS, EMTCT, family planning, HIV prevention, ART and EID, infant and child feeding, SGBV, TB screening, point of delivery) | | | | | | | |

◀ Annex C (cont'd)

| ACTIVITY | RATING 2 | 1 | 0 | VERIFICATION | COMMENT | | |
|---|---|---|---|---|---|---|---|
| **MALL** | | | | | | | |
| Capacity-building | | | | 5 days | | 2 | meets standard |
| Plan of action | | | | 1 | | 1 | Average |
| Home visits | | | | 10 weekly visits | | 0 | Below Average |
| Consultative meetings | | | | 4 | | | |
| Health talks | | | | 5 | | | |
| Registers | | | | Completeness, correctness, confidentiality | | | |
| IEC materials | | | | For various programmes | | | |
| Links to care | | | | Number linked care | | | |
| Guidelines for Integration | | | | Available | | | |
| Follow-up care | | | | Number of visits | | | |
| Demonstration models | | | | 2 per consultation room | | | |
| Provider-initiated services | | | | Number | | | |
| Number of provider-initiated services taken | | | | Number | | | |
| Maternity and new-born services (EID, infant circumcision, TB screening, cancer screening, family planning, HIV prevention, HTS) | | | | | | | |
| Client comes for PNC (human papillomavirus [HPV], HTS, TB screening, ART for women and infants, family planning and commodities, infant and young child feeding, immunizations, maternal nutrition, HIV prevention and commodities) | | | | | | | |
| Client comes for VMMC (HTS, HIV prevention and commodities, TB screening, family planning commodities, Social and Behavioural Change Communication [SBCC], male cancer screening) | | | | | | | |

▶

| ACTIVITY | RATING | | | VERIFICATION | COMMENT | | |
|---|---|---|---|---|---|---|---|
| | 2 | 1 | 0 | | | | |
| client comes for HIV treatment and care (family planning and commodities, pregnancy screening, STI and TB screening, SBCC, cancer screening, lubricants if key population, SGBV, comprehensive education on abortions, nutritional counselling, referral to support system) | | | | | | | |
| Inspect status of counselling rooms | | | | | | | |
| Comes for nutrition support (maternal nutrition, HIV information, infant and young child feeding, TB screening, nutrition screening and EID, Hep B screening, referral to childhood development programme) | | | | | | | |
| Client comes for abortion services (SGBV, cancer screening, HTS, HIV prevention and commodities, TB screening, STI screening, family planning) | | | | | | | |
| Client comes for gynaecological services (cancer screening, HTS, TB screening, comprehensive education on abortion, HIV prevention and commodities, family planning and commodities, emergency contraceptives, STI screening) | | | | | | | |
| Review record-keeping and inventory | | | | | | | |
| Establish if periodic peer-to-peer and supervisor-supervisee observation sessions are conducted | | | | | | | |
| Ascertain timely submission of reports | | | | | | | |
| Enquire about the project relations with DHMT/ DMSAC and other stakeholders and partners | | | | | | | |
| Review actions undertaken during the past supervisory visit | | | | | | | |
| Discuss actions for the next visit | | | | | | | |
| Information sharing with stakeholders | | | | | | | |
| Provide feedback | | | | | | | |
| Share the summary supervisory reports with other stakeholders | | | | | | | |
| Share successes or lessons learned | | | | | | | |
| **Subtotal** | | | | | | | |

# **Annex D:** Supportive Supervision Checklist for supervisors

- Develop an integration supervisory system that focuses on facility activities and achieving facility objectives, rather than on day-to-day individual performance.
- Discuss and agree on an approach to supervision that involves the facility manager and staff as part of the supervisory team.
- Be an advocate for the facility manager and staff to ensure that they can take advantage of educational and training opportunities offered by MoHW.
- Be well prepared for a supervisory visit by reviewing previous recommendations and actions to support facility activities.
- At the end of each supervisory visit, prepare a list of actions with the facility manager (or DHMT if the facility is a health post) and staff that you all agree to implement before the next visit.
- Be committed to providing timely and regular feedback to your facility.

## How to plan for supervision

Budgetary considerations:

- Check with the DHMT to determine the budget for integration supervision at the facility levels.

Supervisory skills:

- Supervisors should be knowledgeable on the integration policies and guidelines. Adequate training aimed at equipping supervisors with the necessary technical expertise is key to the preparation of supervision in health facilities.

Mapping facilities for supervision based on geographical considerations:

- If supervisors cover several facilities within a geographic area, the facilities should be clustered based on proximity to each other.

Plan with the facilities:

- The supervisors need to work with the facilities to plan the dates for supervision.

Develop feedback mechanisms:

- The supervisors should be available to discuss their performance and any missed opportunities identified. Supervisors may also play important roles in helping to prioritize the actions for better integration identified by staff.

Develop strategy for addressing missed opportunities and bottlenecks:

- There are a number of ways supervisors can facilitate resolving gaps and missed opportunities at facility level. For instance, the supervisor may be able to conduct trainings or identify someone else capable of conducting trainings or mentorship. Additionally, the supervisor may be able to identify the resources needed for the facility to improve the integration journey.

# **Annex E:** Supportive Supervision Tool

Supportive Supervision (SS): Ongoing one-on-one mentoring of specific skills to address identified needs which can be conducted in-person through site visits or telephone calls. The aim of SS is to increase the capacity and confidence of health care workers to deliver integrated services.

District_____ Facility_____

Date_____ Fax_____

Phone _____

| SS Activity | Staff Person(s) | Facility Staff | Total Number (indicate if visits) | Other Skills (HTC, Prescriber, Programme Focal Point etc.) | Comments |
|---|---|---|---|---|---|
| | | Medical Doctor<br>Nurse Midwife<br>FNP<br>General Nurse<br>Pharmacist<br>Pharmacy Technician<br>Health Care Assistant<br>Health Education Assistant<br>Orderly<br>Cleaner<br>Driver<br>Gardener<br>Security Guard<br>Project Staff-Linkage Officers<br>Other - Specify | | | |
| **Number Trained on Integration** | | | | | |
| **Status of the following:** | | | | | |
| » **Equipment** | | | | | |
| » **Furniture** | | | | | |
| » **Supplies** | | | | | |
| » **Drug availability** | | | | | |
| » **Commodities**<br>**Pregnancy test**<br>**Urinalysis**<br>**Family planning** | | | | | |
| » **Transport** | | | | | |
| **Status of Implementation of Plan** | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Transition Plan status** | Debriefing | Team building | Sensitization of community and stakeholders | Resource rationalization Staff equipment/ furniture | Skills inventory-already done | |
| | | | | | | |
| **Integration service delivery** | SRH Service Point | ART Service Point | Testing Service Point | General Consultation Service Point | | |
| | | | | | | |
| **Patient flow** | Has been rearranged | Patient-focused | Patients seamlessly linked to services | | | |
| | | | | | | |
| **Use of effectiveness tools (yes or no)** | Block-booking | Task-sharing | Work Improvement Teams | Quality improvement | Community outreach | |
| **Partnerships** | CSOs | Private sector | VDC | | Village extension team | PTAs |
| | | | | | | |
| **Signage (Yes or No)** | Clinic board | Labelling on doors or areas | Arrows on buildings to guide patients | | | |
| **M&E** | Data collection (Integration) | Reporting | Registers | | | |
| **Challenges** | | | Proposed remedial action | | | |
| | | | | | | |
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# **Annex F:** Integrated Service Delivery M&E Framework

## IMPLEMENTATION OF INTEGRATED SERVICE DELIVERY IN SUPPORTED HEALTH DISTRICTS

### Appendix 6.1: Monitoring Framework for Integration in Botswana

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 1.1 Percentage of facilities that block-book patients so that they receive (required and provider-initiated) services on the same day | Number of facilities who report block-booking their patients | Number of facilities in the district | New | Monthly | MoHW (health facilities) | District M&E officers/ Health facility representatives | Monthly health facility reports |
| 1.2 Percentage of facilities that provide all services (required and provider-initiated) to a patient (walk-in) on the same day | Number of facilities who report provision of services required by a patient on the same day (in the past three months) | Number of facilities in the district (in the past three months) | New | Monthly | MoHW (health facilities) | Health facility representatives | Monthly health facility reports |
| 2.1 Percentage of HIV positive adults and children enrolled in HIV care screened for TB | The total number of HIV positive adults and children enrolled in HIV care screened for TB during the reporting period | The total number of HIV positive adults and children enrolled in HIV care | Existing | Monthly | Pre-ART and ART registers | District M&E officers | Monthly health facility report/ DHIS |
| 2.2 Percentage of TB incident cases among HIV positive adults and children on ART | The total number of TB incident cases among HIV positive adults and children enrolled on ART during the reporting period | The total number of HIV positive adults and children enrolled on ART | Existing | Monthly | ART registers | District M&E officers | Health facility report / DHIS |

◀ Annex F (cont'd)

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 2.3 Percentage of active TB cases among adults and children newly enrolled in HIV care | The total number of active TB cases among adults and children newly enrolled in HIV care during the reporting period | The total number of active TB cases among adults and children during the reporting period | Existing | Monthly | ART registers | District M&E officers | Monthly health facility reports/ DHIS |
| 3.1 Percentage of HIV positive family planning clients (women) accessing dual family planning methods | The total number of HIV positive women who were provided with a dual family planning method during the reporting period | The total number of HIV positive women who accessed family planning services during the reporting period | Existing | Monthly | Family Planning register | District M&E officers | Monthly health facility reports/ DHIS |
| 3.2 Percentage of HIV positive women screened for cervical cancer | The total number of eligible HIV positive women who were screened for cervical cancer during the reporting period | The total number of HIV positive women (30-49) who visited during the reporting period | Existing | Monthly | Family Planning register,<br>Pap smear, VIA registers<br>ART registers (denominator) | District M&E officers | Monthly health facility reports/ DHIS |
| 3.3 Proportion of women living with HIV (aged 30-49) who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid (VIA), Pap smear or HPV test | Number of women living with HIV aged 30-49 years old who report ever having had a screening test for cervical cancer using any of these methods: VIA, Pap smear and HPV test. | All women respondents living with HIV aged 30-49 years old | Existing | Annually | | | |

Annex F (cont'd)

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 3.4. Percentage of modern family planning service delivery points providing integrated HIV services | Number of modern family planning service delivery points providing integrated HIV services during the reporting period | The total number of modern family planning service delivery points in health facilities during the reporting period | New | Monthly | Health facilities | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 4.1 Percentage of HIV service delivery points providing integrated modern family planning services | The number of HIV service delivery points providing integrated modern family planning services during the reporting period | The total number of HIV service delivery points in health facilities during the reporting period | New | Monthly | Health facilities | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 5.1 Percentage of clients/ patients who were offered an HIV test | The total number of clients who were offered HIV testing during the reporting period | The total number of clients who visited the facility during the reporting period | Existing | Monthly | HTS and Outpatient (MH1049) registers | District M&E officers | Monthly health facility reports/ DHIS |
| 5.2 Percentage of people living with HIV who know their status | The total number of people living with HIV who know their status during the reporting period | Number of people living with HIV | Existing | Annually/ Every 5 years | Routine system/ Botswana AIDS Impact Survey | Health Statistics Unit | Survey report |
| 5.3 Number of clients/ patients who tested for HIV | The total number of clients who tested for HIV during the reporting period | | Existing | Monthly | HTS, PMTCT Baby testing (0-17 months) and Outpatient (MH1049) registers | District M&E officers | Monthly health facility reports/ DHIS |

◀ Annex F (cont'd)

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 5.4. Percentage of clients/ patients who tested HIV positive | The total number of clients who tested HIV positive during the reporting period | The total number of clients who were tested during the reporting period | Existing | Monthly | HTS, PMTCT Baby testing (0-17 months) and Outpatient (MH1049) registers | District M&E officers | Monthly health facility reports/ DHIS |
| 5.5 Percentage of people living with HIV who are currently on ART | Number of people on ART at the end of the reporting period | Estimated number of people living with HIV | Existing | Annually | ART register | District M&E officers | Monthly health facility reports/ DHIS |
| Percentage of people living with HIV on ART with a suppressed viral load | | | | | | | |
| 6.1 Percentage of antenatal care attendees who tested for syphilis at first antenatal care visit | The total number of antenatal care attendees tested for syphilis at first visit during the reporting period | The total number of first visit antenatal care attendees during the reporting period | Existing | Monthly | MoHW (ANC Register) | District M&E officers | Monthly health facility reports/ DHIS |
| 6.2 Percentage of antenatal care attendees who tested positive for syphilis at first visit who were treated | The total number of antenatal care attendees who tested positive for syphilis at first visit who were treated during reporting period | The total number of antenatal care attendees who tested positive for syphilis at first visit during the reporting period | Existing | Monthly | MoHW (ANC Register) | District M&E officers | Monthly health facility reports |

◀ Annex F (cont'd)

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 6.3 Percentage of ANC service delivery points providing integrated HIV services | The total number of ANC service delivery points providing integrated HIV services during reporting period | The total number of ANC service delivery points in health facilities during the reporting period | New | Monthly | MoHW (ANC Register) | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 6.4.1 Number of male condoms distributed at all service delivery points in health facilities | Total count of male condoms distributed to clients at all service delivery points | | New | Monthly | MoHW | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 6.4.2 Number of female condoms distributed at all service delivery points in health facilities | Total count of female condoms distributed to clients at all service delivery points | | New | Monthly | MoHW | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 7.1 Number of people receiving post-GBV clinical care based on the minimum package | | | New | Monthly | Facility Registers | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 7.2 Percentage of clients that received at least one integrated SRHR, HIV and SGBV service | Number of clients of reproductive age who received an integrated service as per the criteria in selected service delivery sites during the reporting period | Total number of clients of reproductive age served at the service delivery site during the reporting period | New | Monthly | Facility Registers | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |

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◀ Annex F (cont'd)

| Indicator | Numerator | Denominator | New or Already Existing? | Frequency | Data source | By Who? | Where will it be reported? |
|---|---|---|---|---|---|---|---|
| 7.3 Percentage of health facilities providing the full package of PEP for SGBV | Number of health facilities providing the full package of PEP for SGBV | The total number of health facilities in Botswana (in selected districts) during the reporting period | New | Monthly | Facility Registers | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |
| 7.4 Percentage of service delivery points providing full PAC services | Number of health facilities providing the full package of PAC services | The total number of health facilities in Botswana during the reporting period | New | Monthly | Facility Registers | District M&E officers, Heads of facilities or nominated representatives | Monthly health facility reports |

## **Annex G:** Participants in the individual consultations

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|---|---|
| SRH programme management | Ms. L Mokganya |
| GBV | Ms. S Malima |
| RMNCAH +N | Mr. T Rakereng |
| SRHR M&E | Ms. S Phiri |
| Integration Training Coordinator | Ms. E Thomas |
| SRHR/HIV/SGBV Integration Coordination | Ms. G Mudongo |
| NCCAP | Ms. M Rammipi |
| ART and HIV Treatment and Care Programme Management | Ms. D Ramaabywa |
| HIV Preventive Programme Management | Ms. E Dintwa |
| STI Management | Mr. K Kusi |
| Health Information Management Systems | Mr. T Chebane |
| M&E | Ms. P Makuruetsa<br>Ms. J Nawa |
| NCDs | Ms. K Ngombe |
| Community Health Services Advisor | Mr. S Kolane |
| Integrated Health Advisor | Dr. K Thokwane |
| RHMT/DHMT Coordination | Dr. G Gasennelwe |
| Former Director of Health Services, Advisor to PHC | Dr. M Kebabonye Tsie |
| BOFWA Health Programmes | Ms. U Ngwenya |
| WHO Health Systems and Maternal and Child Health | Dr. J Bataringaya<br>Ms. N Monyatsi |
| Botswana GBV Prevention and Support Centre | Ms. L Moalusi |
| Men and Boys for Gender Equality | Mr. D Lunga |

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