



BOTSWANA



RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES

This summary highlights the experiences, results and actions from the implementation of the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Botswana*¹. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

RECOMMENDATIONS

What recommendations did the assessment produce?

General recommendations:

- Continued policy and legal development is required to reduce discrimination against people living with HIV (PLHIV), improve the rights of women and eliminate gender-based violence (GBV), as well as decriminalize sex between men. All of these developments are expected to contribute to a reduction in HIV prevalence.
- The Public Health and HIV and AIDS Departments need to collaborate more strongly in terms of planning, budgeting, training, monitoring and supervision of linked HIV and SRH programmes. Currently a large proportion of providers believe that linkages will require more time and resources, and that resources are constrained. These implications need to be faced directly at the policy, programme and service delivery levels.
- The Public Health Department needs to build on the success of promoting the delivery of linked SRH and HIV services by increasing the availability of such services.
- Information, education and communication (IEC) programmes need to be strengthened at the service level so clients and providers are aware of the linked services that are available, and providers are trained to better support clients in accessing the desired linked services.
- Continued operations research is necessary to investigate:
 - how the delivery of SRH and HIV services can be expanded;
 - how much variation in service type availability and in linking exists within similar facility types;
 - the development of workable protocols for linking services and for communicating solutions to managers, trainers and providers.

Specific recommendations:

- Stronger efforts are required by the Department of Public Health to involve the Department of HIV and AIDS Prevention and Care in linkage issues. The Rapid Assessment findings, especially the high demand for HIV services, may serve to stimulate joint discussions between the Public Health Department and donors.
- The availability of safe and legal abortion services needs to be reviewed and expanded.
- Health providers need to be educated about the rights of PLHIV to have children, as well as which contraceptives are appropriate for PLHIV who do not wish to have children.
- The Ministry of Education should review its policies on the distribution in schools of contraceptives for sexually active students.
- Donor agencies should review their assistance programmes to further support linkages and reduce vertical programming.
- The passage of specific laws to protect PLHIV from discrimination should be encouraged.
- Study findings should be incorporated in joint training programmes for staff at all service facilities.
- Communities and clients should be educated about the availability of various services at different types of facilities.
- Providers' successful promotion of HIV counselling and testing (HCT) for males, the promotion of condom use with males and females, and the promotion of family planning (FP) services with females should all be recognized. Providers should be encouraged to expand these services to all clients.
- There should be careful study of how the non-availability of services is constraining linkages between SRH and HIV services.

1. This summary is based upon: *Rapid Assessment of Sexual and Reproductive Health and HIV and AIDS Linkages in Botswana: A Collaborative Study Conducted by the Department of Public Health and Department of HIV/AIDS Prevention and Care, Ministry of Health, Government of Botswana, World Health Organization, Gaborone and Geneva*, and UNFPA, Gaborone, by R. Miller, L. Miller, M. Bowelo, S. Johnson, P. Weis, L. Maribe, V. Leburu and T. Maotwe, 2008; and *Rapid Assessment of Sexual & Reproductive Health and HIV & AIDS Linkages in Botswana* (PowerPoint presentation), V. Leburu, 2008.

PROCESS

1. Who managed and coordinated the assessment?

- The assessment was conducted by the Department of Public Health and Department of HIV and AIDS Prevention and Care of the Ministry of Health (MOH), WHO and UNFPA.
- The report was published in 2009.

2. Who was in the team that implemented the assessment?

- The assessment team included representatives from the MOH, WHO Gaborone Office, UNFPA and a consultant.
- Six field interviewers were seconded for training and interviewing – five from the Department of Public Health and one from the Department of HIV and AIDS Prevention and Care.

3. Did the desk review cover documents relating to *both* SRH and HIV?

- The desk review covered 15 policy and programme documents on SRH, HIV and related issues for 2003–8.

4. Was the assessment process gender-balanced?

- Of the 119 clients interviewed, 89 were female and 30 male. Females accounted for 75 per cent of interviewees. Male clients interviewed were older than female clients. 91 service providers were interviewed, but information on gender balance is not clear. For the assessment team, three females and three males were involved. It should be noted that the assessment tools did not require the sex of interviewees to be recorded.
- The assessment addressed issues relating to both women/girls and men/boys, including male involvement in SRH- and HIV-related services.

5. What parts of the Rapid Assessment Tool did the assessment use?

- The assessment was based on an early version of the *Rapid Assessment Tool*. It involved desk review, group discussions and interviews to address all three levels of the Tool: policy; systems; and services.
- Some of the instruments were adapted to the Botswana context, including following input from the field interviewers.

6. What was the scope of the assessment?

- The assessment aimed to: assess the supply and demand for SRH and HIV services and their bi-directional linkages at the policy, systems and services levels; and to identify gaps and contribute to the development of a country-specific action plan to forge and strengthen those linkages.
- The assessment covered 12 council districts: Lobatse Town; Letlhakeng sub-district; Kanye/Moshupa sub-district; Kgatleng district; Jwaneng Town; Mabutsane sub-district; Hukuntsi sub-district; Kgalagadi district; Serowe/Palapye sub-district; North-East district; Tutume sub-district; and Boteti sub-district.
- The assessment covered 41 facilities: MOH and faith-based organization (FBO) hospitals (11); clinics (14); health posts (7); youth centres (3); and HCT centres (6). The facilities were selected on a convenience basis, with efforts to maximize diversity and geographic spread.

7. Did the assessment involve interviews with policy-makers from *both* SRH and HIV sectors?

- The assessment involved a group discussion with policy and programme decision-makers and stakeholders from the HIV Department, Public Health Department and local government. Although no civil society organizations attended, follow-up appointments were made with relevant representatives.

8. Did the assessment involve interviews with service providers from *both* SRH and HIV services?

- Interviews were carried out with 91 service providers: 35 in clinics; 26 in hospitals; 12 in health posts; 10 in HCT centres; and eight in youth centres.
- Respondents were classified as service providers and they were not categorized according to their designations. No information was captured about their demographic characteristics. In Botswana, facility-based service providers included doctors, nurses, social workers and midwives.

9. Did the assessment involve interviews with clients from *both* SRH and HIV services?

- The field interviewers aimed to interview up to four clients at each facility.
- In total, 119 clients were reached.
- The majority (89) of the clients were female. Their average age was 28 years (female) and 35 years (male).

10. Did the assessment involve people living with HIV and key populations?

- People living with HIV or from any key population were not specifically identified among the clients interviewed. There was no questionnaire specifically for them, and they were clustered as clients. Some questions to the service providers distinguished PLHIV from other clients by asking about services rendered to them specifically.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- The concept of SRH and HIV integration is established in Botswana, appearing frequently in various policies and guidelines. Greater emphasis is given to the integration of HIV services into SRH services than vice versa.
- National policies that address SRH and HIV mention specific populations, such as young people, women, truckers and sex workers. Other groups – such as men who have sex with men (MSM) and people that use drugs – are not explicitly included.
- The National Gender Programme Framework (1998) addresses women's health and issues such as GBV, although problems in these areas continue to increase.
- There is significant attention to delivering SRH services within a human rights framework.
- Some of the needs of PLHIV are addressed within the National Strategic Framework for HIV and AIDS, but there are no laws that explicitly protect PLHIV from discrimination.
- According to policy-makers, the major challenges to SRH and HIV integration include: the lack of joint planning and budgeting at the central and district levels; the vertical nature of most programme plans; inadequate training and supervision on integration; and human resource shortages.

Funding and budgetary support:

- HIV receives higher financial priority than SRH – representing a challenge to joint budgeting.

2. Systems level

Partnerships:

- It should be noted that SRH and HIV programmes are managed by different government departments, but they do collaborate when the need arises.
- The Reference Group on SRH and HIV Integration, established by the MOH, meets quarterly and has the Director of the Department of HIV and AIDS Prevention and Care as its Co-Chair.
- According to policy-makers, integration is often stronger at the district level than the national level. This is especially the case within smaller facilities – often due to the practicalities of limited human resources (with staff having to perform multiple roles).

Planning:

- There is a need for joint planning and budgeting. At present, the HIV Department has a separate budget to that for SRH.

Human resources and capacity building:

- Training on SRH and HIV are conducted separately, with each making an effort to integrate content of the other.
- Many facilities are affected by lack of personnel, with integration seen as an opportunity to reduce waste of financial and human resources.

Logistics, supply and laboratory support:

- On the logistics side the results show lack of joint planning and budgeting at central and district level. On the supply side it shows that some services were less available than others and it was not clear whether the clients do not know about those services or whether service providers recognize lack of demand and place little emphasis on providing them.

Monitoring and evaluation:

- It should be noted that the tool did not capture information on monitoring and evaluation of the two programmes.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

Availability of SRH services:

- According to the service providers, SRH services are generally highly available. Across the facilities: 88 per cent provide services for FP; 87 per cent sexually transmitted infections (STIs); 69 per cent maternal and child health (MCH).
- The least available SRH services are those related to post-abortion care (PAC) (at 42 per cent of facilities) and GBV (at 22 per cent of facilities).
- FP and STI services are the most widely available SRH services at all types of facilities.
- Clinics provide the widest range of SRH services, while HCT centres provide the narrowest.

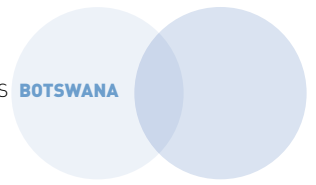
Availability of HIV services:

- According to the service providers, the most highly available HIV service is condom provision (by 90.1 per cent of facilities), followed by HIV prevention for the general population (85.7 per cent) and HCT (84.6 per cent). Most other HIV services are in the mid-range of availability (60 to 79 per cent).
- The least available HIV services are those for sex workers and other key populations (at 11 per cent of facilities).
- Clinics provide the widest range of HIV services, while youth centres provide the narrowest.

- In particular, prophylaxis and treatment are available at more than two-thirds of clinics, health posts and hospitals, but only 40 per cent or less of youth centres and HCT centres.
- Prevention of mother to child transmission (PMTCT) is more available in clinics than in hospitals and is generally not available in youth centres and HCT centres. With the exception of clinics, prongs 1 and 2 of PMTCT services (primary prevention of HIV for women of childbearing age and preventing unintended pregnancies among women living with HIV) are generally more available than prongs 3 and 4 (preventing HIV transmission from women living with HIV to their infants and providing appropriate treatment, care and support to mothers living with HIV, their children and families).

SRH and HIV integration:

- According to the 91 service providers, the main constraints to further integration are: equipment; space; time; training; and motivation. They are also concerned about increased workload and time spent per client.
- The main advantages of integration were identified to include: avoiding missed opportunities to offer services (such as HCT or FP) and reduced stigma of both SRH and HIV clients.
- Among the service providers, 81 per cent reported that they integrate HIV into SRH services and 75 per cent that they integrate SRH into HIV.
- The provision of integrated services is highly dependent on services actually being available at the same facility. The data indicated that – when both types of services are available – there is a high probability of several HIV services (including HCT, prophylaxis and treatment for PLHIV, comprehensive primary and secondary prevention for PLHIV and services for sex workers) being linked with the most common SRH services (such as FP, STIs and MCH). Likewise, there is a high probability that a client seeking HIV services will also be offered SRH services (in particular FP, STI and MCH).



- When HIV services are offered within SRH services, this is most often implemented by the same service provider at the same site on the same day. The least common method is to refer the client to another facility (except youth centres – which frequently refer STI and MCH clients to another facility for HIV services).
- In all types of facilities, when SRH services are offered within HIV services, this is most often by the same provider on the same day. Few facilities of any type refer HIV service clients to another facility for SRH services (except that 30 per cent of health posts, youth centres and HCT centres refer PMTCT clients to other facilities for SRH services).
- Service providers report that they are involved in a number of activities to reorient SRH facilities to support PLHIV and other vulnerable people. These include training, workshops and seminars, especially on PMTCT and provider attitudes. They also report organizing support groups, linking with community support groups and including topics related to HIV within health talks.
- The percentage of clients that received all the services they desired was highest at HCT centres (100 per cent) and lowest at health posts (64.7 per cent).
- Among those clients not receiving all the services they desired, the most common reason was the service not being available (cited most frequently at health posts). Larger proportions of such clients sought additional HIV services compared to additional SRH services.
- Overall, 30 per cent of the clients reported receiving both SRH and HIV services during their visit. Integrated services were most frequent in health posts (47.1 per cent) and least frequent in HCT centres (11 per cent) and youth centres (zero per cent).
- An overwhelming majority (90 per cent) of clients preferred to have SRH and HIV services offered at the same facility. The most commonly cited benefit of such integration was reducing the number of trips, cost and waiting time. The disadvantages were identified as: increased waiting time; and embarrassment of talking about HIV with the provider.

B. SERVICE USER PERSPECTIVES

- The assessment identified that, among the 119 clients, females were more likely to be seeking SRH services and males more likely to be seeking HIV services.
- Female clients' primary reason for visiting a facility was most likely to be MCH (identified by 44.9 per cent), followed by FP (23.6 per cent) and HIV monitoring and/or treatment (20.2 per cent). Males' primary reason was most likely to be HIV monitoring and/or treatment (33.3 per cent), HCT (23.3 per cent), management of STIs (20 per cent), HIV treatment preparedness (16.7 per cent) and condoms (16.7 per cent).
- Female clients received more FP services than they demanded. Males received substantially more HCT than they demanded. Both females and males received substantially more condom services than they demanded. This indicates service providers successfully advising clients to take these services, even if they were not seeking them when they came to the facility.

LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?

- Collaboration, joint planning, budgeting and training is very important between Public Health and HIV and AIDS Departments. Another survey is needed on a larger scale which will be more representative, and a different research method could be used, such as mystery client surveys and observation.

2. What 'next steps' have been taken (or are planned) to follow up the assessment?

- The results have been disseminated through workshops and seminars, cascaded to the district level. The individual departments responsible have each been tracking their own follow-up of the recommendations. Follow-up of recommendations is coordinated by SRH division of the Ministry of Health through the reporting mechanisms of the African Union on integration and convening the National Reference Committee meetings. National strategy has not been developed.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- **policy level?**
- **systems level?**
- **services level?**

Policy level:

- Joint planning and budget.
- Accessing HIV funding for SRH services.

Systems level:

- Joint in-service training programmes.
- Improved involvement during reviews of data collection tools and service protocols etc.

Services level:

- None.

4. What are the funding opportunities for the follow-up and further linkages work in the country?

- There are opportunities for funding, especially with partners such the Global Fund to Fight AIDS, Tuberculosis and Malaria, the European Union, and BOTUSA – a partnership between the US Centers for Disease Control and Prevention (CDC) and the government of Botswana.

Abbreviations

AIDS	acquired immune deficiency syndrome
FBO	faith-based organization
FP	family planning
GBV	gender-based violence
GNP+	Global Network of People Living with HIV
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
MCH	maternal and child health
MOH	Ministry of Health
MSM	men who have sex with men
PAC	post-abortion care
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
SRH	sexual and reproductive health
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

FOR FURTHER INFORMATION, PLEASE CONTACT:

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